COMMUNICATION SKILLS

KEY TO UNDERSTANDING

by Dr. Fayza Rayes

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Although many of the case studies contained in this Handbook are drawn from actual events, every effort has been made to mask the identities and the organizations involved.

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COMMUNICATION SKILLS
Key to Understanding

PREFACE

The Saudi Commission for Health Specialties (SCFHS) yet again adds a feather to its cap by proudly presenting the "Communication Skills: Key to Understanding" book, which we believe would be revolutionary in nurturing a more ethical and meaningful doctor-patient relationship.

Communication is an important skill we all need to acquire early in life to converse with the world around us. Evidently, as adults and healthcare practitioners, we continue to refine this skill further. Communication skills open the gates of understanding, and the better we understand our patients the more efficiently we can diagnose and treat them.

In brief, this book covers the different aspects of communication and explains how to communicate better with patients. At the end of each chapter, you will also find a few self-assessment exercises designed to help you scale your level of understanding. The focus here is mainly on the practical aspects of doctor-patient communication and every doctor has his/her own unique method tailored to their needs. Step by step you will learn how to approach your patients and ease their concerns as well as.

The video version of this book is also available online through the SCFHS website:
http://www.scfhs.org.sa/en/MESPS/TrainingProgs/EduMatActiv/Pages/display.aspx?category=5

This book is designed to take your communication skills to a higher level and I believe it will meet the needs of our healthcare practitioners.

Lack of communication has been the root cause of unsafe, tragic and unsatisfactory healthcare practice; so let's communicate better to avoid the easily avoidable matters.

Professor Abdulaziz Al Saigh
Secretary General
Saudi Commission for Health Specialties

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INTRODUCTION

TRAINING OBJECTIVES

The aim of this book is to educate physicians how to practice a more comprehensive consultation model with effective doctor-patient relationship, using appropriate communication skills.

We shall enhance the traditional doctor-centred consultation model (grey column) with more patient-centred consultation contents (blue column) as well as how to adopt and maintain a good doctor-patient relationship (green column).

Doctor-Centred
➢ Chief complaint ➢ History of present illness ➢ Past medical history ➢ Systems review ➢ Family history ➢ Social history ➢ Drug & allergy history
Physical examination
Biological diagnosis
Disease management
➢ Investigation ➢ Prescribing ➢ Follow-up appointment

Patient-Centred
+ Patient's ideas, concerns, expectation and effects of the problem
+ Psycho-social diagnosis
+ Patient management
➢ Explanation and health education ➢ Reassurance ➢ Health promotion
Management of Doctor feelings

Doctor-Patient Relationship
Establish the relationship
Facilitation
Building rapport
Empathy
Making use of physical examination
Partnership
Closing and maintaining the relationship
Preparation

By the end of this book, one will be able to:

1. Understand patient's illness behaviour
2. Understand patient's verbal and nonverbal communication
3. Use verbal and nonverbal communication more effectively
4. Apply more effective skills in establishing and maintaining doctor-patient relationship
5. Apply a comprehensive consultation model with every patient in daily clinical practice

Benefits of this book

- Identify patients' problems more accurately.
- Patients adjust better psychologically and are more satisfied with their care.
- Greater job satisfaction and less work stress.

- Most of the theories and skills in this book can be applied in personal life, social life and at work in general. It will make life run more easily, successfully and happily.

DISCUSSION

Are there problems in doctor-patient communication?

Do doctors know the real reasons for patients' attendance?

Research shows that:

- Patients bring 1.2 - 3.9 problems at each visit
- Doctors discover only 50% of the patients' problems.
- Doctors interrupt their patients after 18 seconds (Beckman & Frankel, 1984).
- Doctors very often assume that the first complaint mentioned is the only one that the patient has brought.

How do doctors give patients information?

- Waitzkin in 1984, demonstrated that American internists devoted little more than one minute on average to the task of giving information in interviews lasting 20 minutes and overestimated the amount of time that is spent on this task by a factor of nine.
- When doctors provide information, they do so in an inflexible way and tend to ignore what individual patients wish to know. They pay little attention to checking how well patients have understood what they have been told (Silverman et al., 1998).
- There are significant problems with patients' recall and understanding of the information that doctors impart (Tuckett et al., 1985).
- Many studies have shown that doctors not only use language that patients do not understand but also appear to use it to control their patients' involvement in the interview.

Compliance

- On average, 50% of the patients do not take their medicine at all or take it incorrectly (Meichenbaum & Turk, 1987; Butler et al., 1996).
- Non-compliance is enormously expensive. Estimates of the overall costs of non-compliance (including extra visits to physicians, laboratory tests, additional medications, hospital and nursing home admissions, lost productivity and premature death) is 7-9 billion CAN$ in Canada (Coambs et al., 1995) and 100 billion plus US$ in the US (Berg et al., 1993).

Medico-legal complaints related to communication

- Patient dissatisfaction and the perceived absence of caring on the part of physician led to letters of complaint (Beckman, 1995).
- There is a relationship between physician empathy and malpractice sues.
- In USA, 98,000 deaths occur each year because of medical errors. Poor doctor-patient communication was identified as one of the root causes.

Patient and doctor's satisfaction

- 30 - 40% of the patients express their lack of satisfaction from their physician (Schwent & Romana, 1992).

- 60% of the doctors feel unsatisfied and under great job stress (Appleton et al., 1998).
- A review of 25 surveys on doctor-patient relationships concluded that doctors with good bedside manners had a better impact on patients than physicians who were less personal (Ho & Longnecker, 2010).

Do doctors in Saudi Arabia receive appropriate training in this field?

- In the Kingdom of Saudi Arabia, until recently, communication and consultation skills were neither in the curriculum of undergraduate medical colleges nor in postgraduate medical training of most of the medical specialties. In 2015, Saudi Commission for Health Specialties (SCFHS) has revised all the Training Programme Curriculums to adopt the CanMED Model which includes communication skills.
- Some specialties like Family Medicine consider communication and consultation skills part of the training programme, but the training methods in most of these programmes are mainly theoretical.

Is there evidence that training can overcome these problems?

- Many studies over the last 25 years have demonstrated that consultation skills training can make a difference in all of the objective measurements of medical care - it is not just subjective.
- In several states of the USA, malpractice insurance companies award premium discounts of 3 - 10% annually to their insured physicians who attend a communication skills workshop (Carroll, 1996).

FURTHER READING

Kurtz S, Silverman J (1996). The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in Communication Training Programmes. Med Education 30, 83-9

ILLNESS BEHAVIOUR

PATIENT REASONING AND FEELINGS

Illness behaviour can be defined as: How a person feels, thinks and reacts to his/her illness. A patient's health understanding influences the way a symptom is perceived, and what prompts a person to consider him/herself in need of medical advice is a complex decision. It does not correlate with the true seriousness of the illness or the doctor's perception of a need to consult. In other words, patients are poor judges of illness and take decisions often at variance with what doctors believe to be the correct use of the services. The likelihood of deciding to visit the physician depends on many factors which will be discussed in this chapter.

TRAINING OBJECTIVES

- Increase doctors' understanding of patients' suffering.
- Increase doctors' understanding of human behaviour.
- Help doctors' see the full picture of patient's problems (bio-psychosocial dimensions).
- Identify the factors which affect patients' health beliefs and illness behaviour.

CASE SCENARIOS

Case 1

A young healthy man has a low-grade fever. He may react to it by:

- Neglect
- Taking time off work
- Self-medication
- Visiting his Family Physician

Answer: 20% of the patients neglect their illness (Hannay, 1988).

Reasons for illness denial

- It is not easy for a patient to show his/her weakness.
- Doctors are authority figures, and speaking to someone who is supposed to be an authority is often hard for people.
- Cost of consultation.

Case 2

A young healthy lady has a high fever. She may react to it by:

- Neglect
- Taking time off work
- Self-medication
- Visiting her Family Physician

Answer: 75% of the patients may try to help themselves by rest and self-medication (Hannay, 1988).

Reasons for the recent increase in self-care

- Shift from acute to chronic diseases.
- Public dissatisfaction with medical care.
- Recognition of modern medicine limitations.
- Increased visibility of alternative medicine.
- Increased awareness about the lifestyle effects on health.
- Desire to exercise personal control.

As health is the most precious thing anyone can have, anyone who comes to a doctor with a problem is in a disadvantageous position, worried, vulnerable, weak, forced to acknowledge that a problem exists which cannot be coped unaided. The state of illness is also a threat to self-esteem (Balint, 1957).

Case 3

A young healthy lady has a high fever for two weeks. She may react to it by:

- Neglect
- Taking time off work
- Self-medication
- Visiting her family physician

Answer: 5% of the patients visit their Family Physician and only 1% of them need a referral to hospital outpatient. 5 in 1,000 need hospital admission (Hannay, 1988).

Many minor conditions are extremely common and it is normal for people to feel ill a lot of the time, but only small proportions (about 20%) consult their physician while the majority neglect their symptoms/illness. These 20% of the patients are called the clinical tip of the iceberg.

Reasons patients seek medical help

Cecil Helman (1981), an anthropologist, suggested that a patient with a problem comes to the physician seeking answers to six questions:

1. What has happened?
2. Why has it happened?
3. Why me?
4. Why now?
5. What would happen if nothing was done about it?
6. What should I do about it and whom should I consult for further help?

Symptoms (presenting complaint) are not the only reason a patient is seeking medical help for, the real reasons are:

- Patient's beliefs and worries
- Factors affecting patient's beliefs and worries

FACTORS AFFECTING ILLNESS BEHAVIOUR

1. Gender

In general, females use healthcare services more than males as they are more sensitive to their body. The growing body of gender-specific studies highlights a

trend of delayed help seeking when they become ill. A prominent theme among white middle class men implicates 'traditional masculine behaviour' as an explanation for delays in seeking help among men who experience illness (Galdas et al., 2005).

2. Age

Children and elderly are more fragile, this makes them use healthcare services more often than adults.

3. Race

Some races have lower threshold for pain, e.g. Egyptians compared to the British can tolerate pain more.

4. Learned behaviour

Prescribing placebo and referring a patient for unnecessarily investigations will lead to somatic fixation; the patient will assume that his/her complaint is serious, while the truth is the contrary.

5. Accessibility to health services

People living close to healthcare services will be encouraged to seek medical help more often than those who have limited or no access.

6. Previous experience

If an individual's previous experience with health service is positive this will improve his/her compliance, however, if the experience was negative then he/she is less likely to return

7. Lay beliefs

The general population's perception of symptom as being serious or not will affect an individual's decision to whether or not to seek medical help.

8. Social class

Health practices and beliefs are affected greatly by an individual's economic level, way of life, family and culture. In general, low-income people with little or no education prefer alternative medicine more while the high-income educated people use preventive services more.

9. Symptom presentation

Some symptoms are perceived by patients as serious or annoying that need medical attention, e.g. fever or joint pain; however, the psychological symptoms are usually ignored.

10. Trigger factors

Sometimes a patient may feel unable to deal with mild symptoms by self-care, not because of the severity of symptoms, but just because the patient may be feeling weak and exhausted at that particular time due to other psycho-social stressors.

11. Locus of control

Some people have independent personality and they believe everything is under their control, these types of people have "internal locus of control"; such patients try more self-help before seeking medical help. Other people feel they have no control over their life, these types of people have "external locus of control" and they tend to seek more medical help but are frequently less compliant.

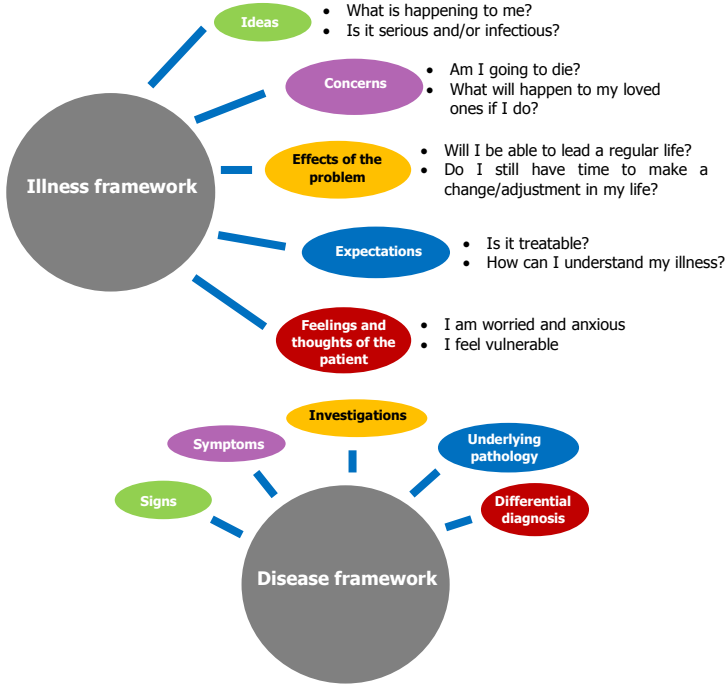
DISCUSSION

- It has been shown that 40 - 80% of patients do not follow the given recommendation by the physician. In many cases, because the recommendation did not fit the question, need or priority that the patients brought to the encounter (Meichenbaum & Turk, 1987; Butler et al., 1996).
- Kindelan and Kent (1987) showed that most patients wanted to know about the prognosis, causation and diagnosis of their condition, whereas doctors underestimated the patients' need for this sort of information, and overestimated the need for information about treatment and drug therapy.
- Discovering patients' expectations leads to greater patient adherence to plans whether or not these expectations are met (Eisenthal & Lazare, 1976).

RECOMMENDATION

When a physician combines the disease framework (physical symptoms) with the illness framework (patient's reaction), he/she will recognize the real reason for the patient's attendance.

- Try to see the full picture of your patient (disease and illness).
- Try to see the unseen feelings and hear the unspoken suffering of your patient.



SELF-ASSESSMENT EXERCISES

Exercise 1

Read the following patient scenarios and speculate the possible perspective of the patient's illness.

Case scenario 1

1. Mrs. Salma is a 28-year-old divorcee, living with her 5 children, working as a teacher. Over the last 12 months, Salma has had intermittent episodes of soreness and stiffness in her knees.

- Possible ideas

_____

_____

_____

- Possible concern

_____

_____

_____

- Possible expectation

_____

_____

_____

- Possible effect of the problem

_____

_____

_____

Case scenario 2

2. Mr. Naser is a 42-year-old teacher. He has chest pain

- Possible ideas

_____

_____

_____

- Possible concern

_____

_____

_____

- Possible expectation

_____

_____

_____

- Possible effect of the problem

_____

_____

_____

Exercise 2

Think of how you might phrase questions to ask patients directly about their

Ideas	
Concerns	
Expectations	
Feelings	
Effect	

Exercise 3

Speculate possible causes of illness denial.

1._____

2._____

3._____

FURTHER READING

Vallis TM, McHugh S (1987). Illness behaviour: Challenging the medical model. Humane Medicine Health care 3(2)

التفاعل مع المرض (من كتاب الأسس العلمية للاستشارة الطبية)

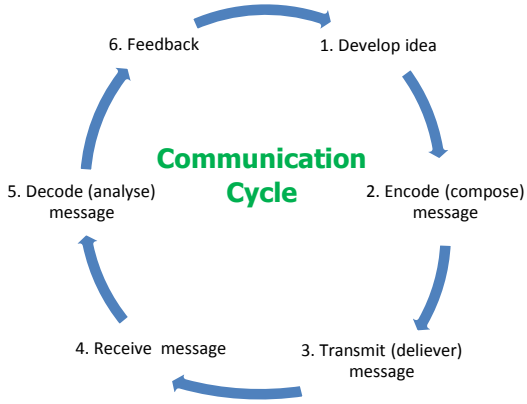
COMMUNICATION

INTRODUCTION

Communication involves the sending and receiving of messages, it is a two-way process. The cycle of communication proceeds through a number of stages and there are different categories of communication: verbal, nonverbal, visual, and written communications. In this book, we shall discuss and focus on two communication categories: verbal (message relayed through the use of sounds and language) and nonverbal (message relayed through gestures, facial expressions, and postures).

TRAINING OBJECTIVES

- Increase awareness of individual communication style.
- Increase awareness of patient's communication style.



COMMUNICATION CYCLE

As mentioned above, in communication, there is a sender and a receiver. In this section, we shall briefly describe the 6 stages of communication individually.

1. Develop idea

To start any communication, an idea (thought) must be developed that the sender wishes to convey to the receiver.

2. Encode (compose) message

In order to express the idea developed, one should structure and choose the appropriate channel and language of communication, bearing in mind the person receiving the message as well as the idea to be delivered.

3. Transmit (deliver) message

In this stage, the message encoded is sent to the receiver through a selected medium of communication (verbal or nonverbal).

4. Receive message

Once the message is transmitted, it is sent by the sender and is received by the receiver.

5. Decode (analyse) message

During this phase, the receiver must analyse the message transmitted by the sender and interpret it in order to comprehend the message.

6. Feedback

Finally, feedback is provided by the receiver to assess whether he/she has received, comprehended, and correctly interpreted the message delivered to him/her. Accordingly, the sender will either proceed with communication or provide clarification if needed.

HOW TO IMPROVE COMMUNICATION

- **Learn to listen**. Hearing does not mean listening, hence, pay attention to what your patients say, verbally or nonverbally (*these categories of communication will be discussed further in the coming chapters*).
- **Select words appropriately**. Always be careful of the words you select to communicate with others. The wrong choice of words could lead to unwanted misunderstanding between doctor and patient.
- **Relax**. The more nervous you are the more you tend to speak quickly and less clearly. Remember your patient is coming to you for help and not to be confused or undermined.
- **Be optimistic**. Most people appreciate and prefer positive individuals. This could be done by letting your patients know that you will continue to help them and hopefully find a solution to their health issue. However, remember not to give your patients false hopes that you cannot achieve as this will just damage your credibility.
- **Empathise**. Try to see and understand other people's perspective or concerns; this way you can learn new things while gaining the respect and trust of others. For example, if a patient is terminally ill or is worried about a treatment method due to any personal values/reason, try to associate yourself to their situation and give him/her words of kindness and support by letting him/her know that he/she is not alone.
- **Learn to be assertive**. Avoid being aggressive, stubborn and a know-it-all. Try to express your opinion in a way that others can understand and respect. As we all know, patients can sometimes be difficult to manage due to their social status, education level, religious beliefs, etc. However, a successful doctor can guide his/her patient more easily by gentle persuasion and flattery than by hostile confrontation.
- **Reflect and improve**. Learn from your past mistakes and successes. The only source of knowledge is experience (Albert Einstein).

COMMON BARRIERS TO EFFECTIVE COMMUNICATION

- **Use of jargon**. Physicians sometimes fail to remember that the everyday medical terminology they use are confusing to a layperson, e.g. using the word epistaxis instead of nosebleed.

- **Lecturing without feedback**. This occurs when a physician delivers a large chunk of information without giving the patient a chance to respond or ask questions. While it may seem efficient to the physician, patients are often unable to follow the pace of the physician's information delivery (Back et al., 2005).
- **Emotional barriers, cultural differences and taboos**. Some patients find it difficult to express their concerns due to self-conscious emotions, e.g. shame, guilt or embarrassment because they consider them to be 'off-limits' or taboo. Help your patients open up to you by making him/her feel comfortable and safe to share his/her concern.
- **Lack of attention, interest, distractions, or irrelevance**. This occurs when the receiver is not interested about the sender's message and there is no shared understanding between the patient and his/her physician.
- **Passive listening**. Physician listens to the patient without giving any feedback, verbal or nonverbal, that would encourage the patient to continue/elaborate further.
- **Blocking**. This happens when the physician neglects the patient's concerns by either failing to respond to his/her query or redirecting the conversation.
- **Collision.** Patients hesitate to bring up difficult topics and physicians do not ask them specifically - a "don't ask, don't tell" situation. Patients often assume that if something is important then the physician will mention it, whereas physicians assume that if patients want to know anything, they will ask.
- **Physical barriers to nonverbal communication**. Physicians fail to interpret their patient's nonverbal cues (signals), gestures, posture and general body language, making doctor-patient communication less effective. Nonverbal cues are as important as verbal communication since it conveys more emotional and affective meaning than does verbal communication.
- **Language differences and the difficulty in understanding unfamiliar accents**.
- **Premature reassurance**. This occurs when a physician responds to a patient's concern with reassurance before exploring and understanding his/her concern.

RECOMMENDATION

Confusion can occur during any stage of the communication process. Reducing possible misunderstandings and overcoming any barriers to communication at each stage in the communication process contribute to effective communication.

To effectively communicate with your patients you need to understand your patients, choose your language/terminology appropriately and improve your message in order to reduce misunderstanding. Always ensure that your patient understands your message by asking if they need further clarification or if they have any questions and/or concerns regarding the information provided to them. Correct any misunderstanding or confusion as soon as possible.

SELF-ASSESSMENT EXERCISE

Exercise 1

List what are the effective doctor-patient communication skills and what make doctor-patient communication ineffective

Effective Doctor-Patient Communication	Ineffective Doctor-Patient Communication

VERBAL COMMUNICATION

INTRODUCTION

Effective communication skills are the key features needed to exchange information and feelings between physicians and patients. Having good communication skills is very essential to build-up effective physician-patient relationship.

TRAINING OBJECTIVES

- Increase learner's self-awareness about their own communication method.
- Increase learner's accuracy, efficiency, supportiveness and effectiveness in dealing with patients.

VERBAL COMMUNICATION PROCESS

- **Preliminary communication**. Appropriate greeting with a smiling face along with a handshake and introducing yourself while maintaining eye contact are important. Remember, first impressions have a lingering effect.
- **Reinforcement**. Encourage the patient to discuss their concern and illness. Boost the patient to elaborate further, maintain eye contact, nod your head as he/she speaks with warm facial expressions and show interest in his/her concern. This will encourage your patient to openly express him/herself.
- **Effective listening**. Avoid distractions, always pay close attention to the patient, maintain an open mind, and concentrate on what he/she is saying. Avoid interrupting the patient and hold back your conclusions and/or questions until he/she finishes speaking. Remember to always remain objective.
- **Questioning**. Through questioning you can obtain further relevant information which will assist you to achieve diagnosis. By questioning you can assess whether you have understood what the patient is trying to say. Ask your patient only one question at a time and wait for his/her reply before asking the next question. The main types of questioning are:
  - **Open-ended questions**. Open questions give more room for response since they call for further discussion and explanation. Open questions take longer to answer; however, they do give far more opportunity for self-expression and encourage participation in the discussion.
    - **Leading or 'loaded' questions**. A leading question, usually delicately, points the respondent's answer in a certain direction. This gives away or suggests to the patient what answer you expect. For example, "You said you were feeling miserable, could you tell me more?"
    - **Recall and process questions**. Queries can also be characterized as 'recall' - requiring something to be remembered or recalled, or 'process' - requiring some deeper thought and/or analysis. 'Recall' example, "When did you first start to

experience these symptoms?. 'Process' example, "What do you think may have been the triggering factor of these symptoms?

- **Closed-ended questions**. Closed questions are aimed to seek only a one or two word answer (usually simply 'yes' or 'no'). However, by doing so, one limits the range of the response. These types of questions control the communication and limit verbal communication. All the same, closed questions can be beneficial for directing discussion and attaining clear, concise answers when needed.
- **Funnelling**. Funnelling uses perceptive questioning to basically funnel the patient's answers, i.e. to ask a series of questions that become more (or less) restrictive at each step, starting with open questions and ending with closed questions or vice-versa. This approach often confuses the patient as he/she may feel rushed or put down. If any of these feelings are present, the patient is not likely to give meaningful information. The one specific use of funnelling is to encourage a quiet patient to take responsibility and talk more freely.

- **Reflecting and clarifying**. Reflecting is the practice of clarifying your understanding of what the patient has said to you. In other words, you summarize your patient's message in your own words, outlining the core facts and feelings expressed, in order to communicate your understanding back to the patient. This process will show the patient that you were attentive to what he/she has said while assessing your understanding of their concern.
- **Closing communication**. At this stage of the communication you should be able to provide your diagnosis based on the information the patient has provided you. Remember you have to ensure the patient has understood the condition and is satisfied with the information provided before closing the communication.

How to convey illness diagnosis and health education to a patient

To explain to your patient your diagnosis and provide him/her with the proper health education, you have to:

- Briefly introduce what you are going to explain
- Ask the patient about his/her knowledge of the illness or condition
- Listen to the patient with empathy
- Start conveying the education message with:
  a. Positive attitude towards the diagnosis.
  b. Simple language, avoiding jargon.
  c. Appropriate patient education.
  d. Convincing scientific evidence.
  e. Prioritize and categorize information.
  f. Organized and limited (5-7 message role or less)
- Watch the pace, check repeatedly for the patient's understanding and feelings as you proceed and take feedback. Basically, avoid lecturing.
- Give the patient opportunity to ask questions.
- Respond immediately and appropriately to patient's cues (signals).
- Summarize to the patient what you have explained to him/her

- Use demonstration as much as you can
- Give hope and support

BENEFITS OF PATIENT HEALTH EDUCATION

Patient health education is any set of strategic educational information or activities aimed to improve patients' health manners and health status. Its main purpose is to conserve or improve patient health and sometimes decrease deterioration. By avoiding lecturing and providing patients with the required information and education, a patient can enthusiastically partake in his/her own treatment, improve results, aid recognize mistakes before they happen, in addition to reducing his/her period of illness or just simply controlling it. Listed below is a list of the benefits of patient health education:

- Simplify understandings of health statuses, diagnosis and treatment options, and concerns of care for patients and their families.
- Increase a patient's capacity to handle and manage his/her health.
- Promote rehabilitation to improve function
- Support patients to learn better health behaviours
- Increase patient's ability to adhere to a healthcare plan
- Allow a patient to partake in the decisions related to their care
- Decrease treatment complexities
- Increase patient self-confidence in his/her self-sufficiency

RECOMMENDATION

In the previous chapters, we discussed how illness can make patients feel weak and vulnerable. By now, you should be equipped with the necessary skills needed to break any barrier in order to establish a good connection with your patient. Keep in mind, that the more comfortable a patient feels with his/her physician, the more he/she will give important and relevant information about their symptoms without hesitation. Once this connection is established, diagnosing and treating your patient will become more relaxed and efficient.

SELF-ASSESSMENT EXERCISE

Exercise 1

Explanation and health education: Self-evaluation form

Patient Data:_____ Age:_____ Gender:_____

Reason for attendance:_____

Skills	0	1	2
1. Give introduction about the importance of the topic 2. Explore patient knowledge and feelings 3. Empathic listening 4. Deliver message in a positive way (reassurance) • Make your message simple & clear • Make it appropriate to the patient's education level • Make it a convincing message (logical explanation) • Make it organized & limited			

5. Frequently take feedback			
6. Invite patients to ask questions			
7. Response to patient's cues			
8. Repeat if necessarily (T3) • T1: Tell him what you will tell him (Introduction) • T2: Tell it • T3: Tell him what you have told them (Summary)			
9. Use demonstration if appropriate			
10. Always give hope and support			

0 = not done; 1 = done but not good enough; 2 = perfectly done

1. Write your feelings about your performance:

……

……

2. Important areas of strength and areas that need improvement:

……

……

3. Your specific learning needs and your action plan:

……

……

NONVERBAL COMMUNICATION

INTRODUCTION

Within any interaction between two people, over 90% of the communication that occurs is channelled through the nonverbal band. Nonverbal behaviours allow the observers to discern people's emotional state, e.g. happiness, anger, surprise, fear, disgust, sadness, etc. Nonverbal communication is a universal language, with some nonverbal cues (signals) having different meanings in different cultures. Nonverbal communications include: facial expressions, tone of the voice and gestures displayed through body language. These non-verbal signals can give clues and additional information and meaning in addition to the spoken (verbal) communication. Verbal communication alone would not have significant effects on a patient's satisfaction and health outcomes.

Non-verbal communication is an extremely confusing yet integral part of our daily overall communication. People are often unaware of the non-verbal behaviour they use. A basic understanding of non-verbal communication strategies, in addition to what is actually said, will help improve your interaction with others. Knowledge of these signs can be used by physicians to encourage their patients to talk about their concerns; consequently, leading to a greater shared doctor-patient understanding.

Moreover, in order to communicate effectively, avoid misunderstandings, and enjoy solid, trusting relationships both socially and professionally, it's important to understand how to use and interpret nonverbal signals.

TRAINING OBJECTIVES

- Increase understanding of nonverbal cues.
- Learn how to recognize patients' nonverbal cues.

ASPECTS OF NONVERBAL COMMUNICATIONS

Body language or body movements

Gestures or body movements are an important form of communication. Patient's attempts to mask feelings can be detected readily by observing their body behaviour. Conversely, by using appropriate body language, the physician can convey his/her attention and concern in the most effective manner possible.

Body language includes gestures, facial expressions, body postures, and eye contact.

Facial expression: The face is perhaps the most important conveyor of emotional information; it can express enthusiasm, energy, approval, confusion or boredom and scowl with displeasure. The eyes are particularly expressive in telegraphing joy, sadness, anger, or confusion.

Body postures: Our body postures can create a feeling of warm openness or cold rejection. For example, when someone faces us, sitting quietly with hands loosely folded in the lap, a feeling of anticipation and interest is created. A

posture of arms crossed on the chest portrays a feeling of inflexibility. The action of gathering up one's materials and reaching for a purse signals a desire to end the conversation.

Gestures: Gestures are woven into the fabric of our daily lives. We wave, point, beckon, and use our hands when we're arguing or speaking animatedly - expressing ourselves with gestures often without thinking. However, gestures can be different in various cultures and regions, so be careful to avoid misinterpretation.

Eye contact

- **Giving and receiving feedback:** Appropriate eye contact is an expression of respect and interest on the content of the speech. Communication may not be a smooth process if a listener averts their eyes repeatedly, however, bear in mind that prolonged eye contact or staring can be an expression of aggression. Lack of eye contact gives clues to presence of anxiety, depression, masked emotions, lack of security and confidence as well as negligence and disrespect.
- **Signalling 'turn' to speak:** Changing eye contact with verbal communication can be considered a meaningful cue. When someone is listening, eye contact is more likely to be continuous rather than when he/she is speaking. When a person has finished speaking, he/she will look directly at the other person giving him/her the signal that it's his/her turn to speak. If someone wishes not to be interrupted while speaking, eye contact may be avoided.
- **Communicate something about a relationship between people:** The size of the pupil changes with the mood of the person, e.g. if you despise someone, you tend to avoid eye contact and your pupil size is often reduced. Alternatively, maintaining positive eye contact signals interest or fascination. There are racial variations in the explanation of eye contact.

Positive and negative body language

Positive	Negative
• Maintaining eye contact with the person to whom you are speaking. • Smiling (if appropriate) but especially as a greeting and when parting. • Sitting squarely on a chair, leaning slightly forward (this indicates you are paying attention). • Nodding in agreement. • A firm handshake. • Presenting a calm exterior. • Looking interested.	• Not looking at a person when speaking. • Tapping a foot, fingers etc. • Rocking backwards and forwards. • Scratching. • Continually clearing your throat. • Fiddling with hair, ear lobes, jewellery, jacket, glasses, etc. • Picking at fingers or finger nails. • Yawning. • Repeatedly looking at your watch or a clock in the room. • Standing too close to others. • Inattention to a person who is speaking.

Appearance

How the patient dresses, says a lot about him/her, such as: social class, mood, beliefs, attitude, etc.

How the physician dresses is also important. Clothing has been found to affect perceptions of credibility, likeability, attractiveness, and dominance. Researchers agree that clothing has the most potent effect on credibility.

Closeness and personal space

In every culture and society there are different levels of physical closeness appropriate to different types of relationship. People learn these different distances from the society they grew up. As a physician, you encounter patients from multicultural society, as a result you must know the importance of considering the range of non-verbal codes as expressed in different ethnic groups. When someone disregards an 'appropriate' distance, people may feel uncomfortable or defensive. Their actions may well be open to misinterpretation.

A close personal interest in the patient can be communicated by the appropriate use of touch. The most socially acceptable method is a handshake, which enables a physician to establish early contact with his/her patient. Physical examination is another opportunity to use touch to communicate reassurance and support. For example, when performing a physical examination, make sure you explain to the patient that you may do something that might be painful. This would prepare the patient for any pain that might arise.

Listed below are the four main categories of proxemics, these zones are affected by factors such as culture, status, role, etc.

- **Intimate Distance** (touching to 45 cm): This is the zone we classify as our own property. Only those who are emotionally close to us are permitted to cross the threshold. This includes close family and friends.
- **Personal Distance** (45 cm to 1.2 m): It is the distance over which we interact at social events with our friends.
- **Social Distance** (1.2 m to 3.6 m): It is the distance at which we stand when meeting new people and interacting with groups of people.
- **Public Distance** (3.7 m to 4.5 m): It is a comfortable distance to maintain between strangers in public.

Paralanguage

Paralanguage relates to all aspects of the voice which are not strictly part of the verbal message, including the tone and pitch of the voice, the speed and volume at which a message is delivered, and pauses and hesitations between words. These signals can serve to indicate feelings about what is being said. Emphasising particular words can imply whether or not feedback is required.

- **Volume:** Without enough volume you cannot be heard. However, shouting or a harsh sounding voice may be perceived as disruptive or

insulting. Many a times, lowering your voice almost to a whisper will help you make a point better than shouting.

- **Pitch:** Most factual communication includes moderate changes in the pitch of your voice. A monotone involves little or no change and may be perceived as apathy or boredom. Try to make the conversation engaging and bear in mind that when you are agitated or even enthusiastic, vocal chords tense and shorten causing the voice to get higher. Emphasise certain words and remarks within the conversation to convey their importance and help add variety.
- **Pace:** This is the speed at which you talk. A slow pace of speech may frustrate the patient. An increasing pace may be perceived as increasing intensity. A fast pace may be perceived as nervousness and it may also be difficult to understand. Try to vary your pace, this would help maintain interest.
- **Rhythm:** The regular or rhythmic voice pattern will normally make you sound more confident or authoritative. Irregular speech rhythm might be perceived as thoughtful or uncertain, depending on your words and other nonverbal messages used.
- **Articulation/Pronunciation:** Some people speak through clenched teeth with little lip movement, causing the sound to be trapped in the mouth and not out. To have good articulation one must unclench the jaw, open the mouth and properly enunciate each sound, paying particular attention to the ends of words. This would help the listener as a certain amount of lip-reading will be possible. To be understood, you must also use the correct sounds and emphasis on pronouncing each word. Mispronouncing a word might be perceived as indicator of ignorance or incompetence. When words are spoken clearly, it makes it easier for the listener to understand what is being said.

Environment

Clinic setting can convey a positive nonverbal message about the physician to a patient if arranged in the correct manner. A clinic should be coloured in relaxing colours, welcoming, clean, well-organized and containing basic professional equipment. The correct placement of the furniture in the clinic could put the patient at ease and feel less terrified.

For example, some physicians place their tables and patient's chair 45 cm - 1.2 m apart (personal distance zone); as shown in the figure below.

The advantages of this type of setting for doctor-patient communication are:

- The patient is in the personal zone and treated as a friend.
- It is a good balance between professional and intimate relationship.

- The computer and desk are not barriers.
- Physician can distance him/herself if needed, e.g. to grab an anatomical model to explain further to the patient, or grab the sphygmomanometer to check his/her patient's blood pressure, etc.
- The physician can also view the patient's nonverbal communication.
- Touch the patient in order to console/reassure him/her and/or express empathy.

ROLE OF NONVERBAL CUES

Most of the time, we attribute the meaning of words, not from the words themselves but from the nonverbal communication. Nonverbal cues can play five roles:

1. **Repetition:** They can repeat the message the person is making verbally.
2. **Contradiction:** They can contradict a message the individual is trying to convey.
3. **Substitution:** They can substitute verbal message. For example, a person's eyes can often convey a far more vivid message than words do.
4. **Complementing:** They may add to or complement a verbal message. For example, a physician who pats a patient on the back in addition to giving supportive comments can increase the impact of the message.
5. **Accenting:** Non-verbal communication may accent or underline a verbal message.

HOW SMART PHYSICIANS COMMUNICATE

- Smart physicians understand the importance of nonverbal communication. They use it to increase their effectiveness, and understand more clearly what their patients are really saying.
- Smart physicians ensure consistency between their verbal and nonverbal messages. When messages are inconsistent, the patient may become confused. Inconsistency can also create a lack of trust and weaken the chance to build a good doctor-patient relationship.
- When a patient sends a message with conflicting verbal and nonverbal information, a smart physician believes the nonverbal information.
- Smart physicians can pick up non-verbal cues and use them to facilitate communication. For example, *"You sound sad when you talk about your father.* I sense that you're not quite happy with the explanations you've been given in the past. Is that right?"

Tips for reading nonverbal communication

- **Pay attention to inconsistencies.** Nonverbal communication should support what is being said. Ask yourself, "If the person is saying one thing, and their body language something else?." For example, are they telling you "yes" while shaking their head no?
- **Look at nonverbal communication signals as a group.** Don't read too much into a single gesture or nonverbal cue. Consider all of the nonverbal signals you are receiving, from eye contact to tone of voice and body language. Taken together, are their nonverbal cues consistent - or inconsistent - with what their words are saying?

- **Trust your instincts.** Don't dismiss your gut feelings. If you get the sense that someone isn't being honest or that something isn't adding up, you may be picking up on a mismatch between verbal and nonverbal cues.

DISCUSSION

- Only 7% of doctors actively encouraged their patients to elaborate.
- 13% listen passively
- 81% make no effort to listen or deliberately interrupt their patients.

The conclusion here is that patients are keen to disclose their own thoughts and feelings which doctors unfortunately ignore! (Tuckett et al., 1985)

RECOMMENDATION

As a smart, professional and caring doctor, you should effectively use your nonverbal communication skills to convey positive messages about yourself. When your nonverbal signals match up with the words you're saying, they increase trust, clarity, and rapport. When they don't, they generate tension, mistrust, and confusion.

Moreover, if you want to become a better communicator as a physician, it's important to become more sensitive, not only to the body language and nonverbal cues of your patients, but also to your own. Pay attention to your patients' nonverbal cues and respond immediately and appropriately to their cues.

As you continue to pay attention to the nonverbal cues and signals you send and receive, your ability to communicate will improve.

SELF-ASSESSMENT EXERCISES

Exercise 1

1. State the different aspects of nonverbal communications:

a)_____

b)_____

c)_____

d)_____

e)_____

f)_____

Exercise 2

1. Write down three words that best describe the way you want to be perceived by your patients:

a)..... b)..... c).....

2. Write down how can you use your communication skills to convey these positive messages about yourself?

a. .....

b. .....

c. .....

FURTHER READING

مهارات الاتصال (من كتاب الأسس العلمية للاستشارة الطبية)

DOCTOR-PATIENT RELATIONSHIP

INTRODUCTION

Effective doctor-patient communication is the fundamental skill of medical practice which consists of both verbal and nonverbal processes. Even the most knowledgeable and skilled physician will have limited effectiveness if he/she was unable to develop effective relationship with his/her patient. Failure to develop good doctor-patient relationship will make working with the patient a very stressful job.

Medical consultation is not only for gathering information in order to reach diagnosis; it is also the foundation on which the doctor-patient relationship is established. During consultation, patients share information and physicians get a chance to know their patients more as a people rather than only patients coming in for treatment.

In this chapter, we shall discuss the different types of doctor-patient relationship as well as the 8 steps for establishing and maintaining effective doctor-patient relationship.

TRAINING OBJECTIVES

- Explain the basic communication skills needed during consultation.
- To increase learners' knowledge and skills in establishing and maintaining effective doctor-patient relationship.

WHY IS DOCTOR-PATIENT RELATIONSHIP IMPORTANT?

- Increases patient care and satisfaction
- Better patient compliance
- Increases physician satisfaction
- Improves quality of healthcare
- Effective use of resources

TYPES OF DOCTOR-PATIENT RELATIONSHIPS

Here, we will briefly discuss four types of doctor-patient relationships.

1. Default - Patient and doctor have low control

This type of relationship lacks sufficient direction because the patient adopts a passive role even when the doctor reduces some of his/her control. Some patients are nervous or shy to adopt a more participative relationship. This type of relationship is neither professional nor effective.

2. Paternalism - Doctor has high control (Disease Model)

In this type of relationship, the physician is dominant and acts as a 'parent' figure that chooses what he/she believes to be in the patient's best interest. This form of relationship traditionally branded medical consultations and, some patients even found it comforting to be able to rely on the doctor and be relieved of burdens of worry and decision making. Nowadays, medical consultations have become increasingly characterized by higher patient control and relationships based on mutuality. The negative aspects of this type of relationship are:

- It follows the traditional medical consultation
- Nobody accepts paternal authority these days
- Poor compliance
- Low patient satisfaction
- It is very exhausting for the physician because he/she takes full responsibility instead of the patient

3. Consumerism - Patient has high control

A consumerist relationship describes a situation in which the patient takes the active role and the doctor adopts a fairly passive role, agreeing to the patient's requests for a second opinion, referral to hospital, a sick note, etc. This is typical in private practice. The negative aspects of this type of relationship are:

- High-risk for the patient
- Exhausting for the physician
- Waste of resources

4. Mutuality (Partnership) - Patient and doctor have high control (Illness Model)

A relationship of mutuality is characterized by the active involvement of patients as more equal partners, where both patient and physician participate in the exchange of ideas and sharing of belief systems. The physician brings his/her clinical skills and knowledge to the consultation in terms of diagnostic techniques, knowledge of the causes of disease, prognosis, treatment options and preventive strategies, and patients

bring their own expertise in terms of their experiences and explanations of their illness, and knowledge of their particular social circumstances, attitudes to risk, values and preferences. The highlights of this type of relationship are:

- Respect for patient's mind and feelings
- Better compliance and patient satisfaction
- Sharing responsibility with the patient
- Sharing uncertainty with the patient
- Challenging and stimulating for the doctor
- Too much empathy and negotiation sometimes exhausting for the doctor

8 STEPS TO DEVELOP GOOD DOCTOR-PATIENT RELATIONSHIP

The patient's first visit is vital; as it can either lead to a good therapeutic doctor-patient relationship or it may end in dissatisfaction, leaving the patient in search for another care provider. In the first few minutes of the encounter, the patient will decide whether or not he/she will feel comfortable with his/her selected physician. Keep in mind that most of this first impression is not made on what the physician says, rather on how he/she says it and how he/she interacts with the patient. Patients must feel that they are treated with respect, at all times. Once physicians understand their patients' background, they can effectively communicate with patients to best help them.

Below are 8 steps, discussed individually, that could help you develop a good doctor-patient relationship.

Step 1. Establishing the relationship

Greet the patient

- Call the patient by his/her surname. Never call a patient over the paediatric age group by their first name without permission, it is disrespectful.
- Stand, smile and shake (SSS) the patient's hand.
- Introduce yourself and indicate your role to the patient.
- Use appropriate welcoming phrase.
- Show the patient where to be seated but never stand over the patient; the patient should not have to look up to you to make eye contact.

Remember, first impression is the last impression; you will never get a second chance to make a first impression.

Socialize with the patient

Patients are normally nervous meeting the doctor for the first time. Put the patient at ease and build rapport by inquiring about non-medical areas of his/her life in the first few minutes to assist in developing a relationship with them as a person. Below are a few types of questions you may ask before asking the patient to tell his/her story and explain why he/she is there:

- Ask male patients about his work
- Ask female patients about her family
- Ask children about their school activities
- Talk to elderly patients about the nice good old days

Advantages of establishing consultation by greeting and socialization

- It creates a positive first impression
- It conveys respect
- It builds trust
- It breaks the ice and puts patient at ease
- It encourages openness
- It improves our own satisfaction

Step 2. Facilitation

Facilitation is the technique used to encourage the speaker to elaborate more, overcome his/her anxiety or hesitancy and express his/her story in addition to his/her emotions.

We need to balance carefully, facilitation and active listening on one hand and on the other hand, focus on guiding the patient to the right direction in order to use time effectively.

Nonverbal facilitation

- Minimize distractions. Close the door, put your beeper and mobile on silent mode during consultation.
- Maintain eye contact. Maintaining eye contact will show the patient that the physician is paying attention to what is being said.
- Active listening. Concentrate of what the patient is communicating verbally and nonverbally taking into account both facts and emotions.
- Nod appropriately. By mirroring the patient's tone, the physician would let the patient know that he/she is on the same page with him/her.
- Touch. When appropriate, you could hold the patient's hand to console him/her or you could give a gentle pat on the back, etc.
- Posture. Lean forward and do not cross your arms.

Verbal facilitation

- **Questioning and listening.** Using of open-ended questions gives the patient a chance to be in control and direct the attention to the most important points from his/her perspective and this will facilitate communication for more details. Patients can offer great insight into their conditions from what they say, therefore, it is necessary to limit the number of times questions. Moreover, avoid interrupting the patient when he/she presenting his/her chief complaints.
- **Probing.** A response that may restate a question in a different way using different words or may even ask the same question. In telling about their symptoms, patients do not give you all the details you need. Once they have told you about a phase of the illness, it may be necessary to probe for more specific information. Ask the patient about any alternative treatment that he/she may be using or used recently.
- **Confrontation.** A response that points out to the patient's feeling, behaviour or previous statement. Confrontations are most effective in focusing the patient's attention upon his/her feeling, behaviour, or statement. They may also let the patient know that you understand what he/she said and this may encourage the patient to explore his/her feelings

further. Seek to identify or clarify the patient's feelings by saying "Tell me how you're feeling about this…." or "I have the sense that…"

- **Paraphrasing.** This is a concise statement of the patient's message content. A paraphrase should be brief and focus on the facts or ideas of the message rather than feeling. The paraphrase should be in the physician's own words rather than "parroting back", using the patient's words. Ask the patient to correct or add to your responses until he/she confirms your understanding, e.g. "Did I miss anything?".
- **Verbal mirroring.** Verbal mirroring is another form of mirroring; it occurs when the physician approximates the patient's voice tone and repeats the patient's last few words and occasionally uses a slight questioning inflection. This mirroring process avoids distorting the patient's words and encourages the patient to say more, e.g. "Do your headaches get worse when under stress?". This would encourage the patient to explore more into this point and also show your attention.
- **Reflection.** It is a response that repeats, or echoes a portion of what the patient has just said. Although it focuses on a particular point, a reflection helps the patient to continue in his/her own style. For example, when a patient comes in and asks you "Doctor, do you think it's cancer?", try to reflect the patient's comment back at him/her, "Do you really think it's cancer?". By using reflection, you encourage the patient to think out loud about his/her deep thoughts and fears.
- **Interpretation.** This is the discussion between you and patient based upon two or more events presented in a manner to tie the events together to reach a conclusion. Try not to jump around from one topic to another. At this stage, you can ask any forgotten question(s) you needed to ask as long as you use transition statements so the patient knows where you are going. Transition statements summarize and enable you to process. The patient should be able to understand what the purpose of any question would be.
- **Summarising.** Here, the physician pulls together the main ideas and feelings of the patient to show understanding. This skill is used after a considerable amount of information has been shared. It will reveal whether or not the physician grasps the total meaning of the message. It also helps the physician gain an integrated picture of what he has been saying.

Step 3. Building rapport

Rapport is a state of balanced understanding with another individual or group that enables greater and easier communication. In other words, rapport is getting on well with another person, or group of people, by having things in common; this makes the communication process easier and usually more effective. Rapport can also be built and developed by finding common ground, developing a bond and being empathic. Creating rapport at the beginning of a conversation with somebody new will often make the outcome of the conversation more positive. However stressful and/or nervous you may feel, the first thing you need to do is to try to relax and remain calm, by decreasing the tension in the situation, communication becomes easier and rapport grows.

Although initial conversations can help us to relax, most rapport-building happens without words and through non-verbal communication channels. We create and maintain rapport subconsciously through matching non-verbal signals, including body positioning, body movements, eye contact, facial expressions and tone of voice with the other person.

As a physician, you must put away your own opinions and principles and abstain from projecting them onto your patient. The medical problem or issue is not about the physician, but about the patient and his/her belief system and the physician needs to comprehend it from their viewpoint. Understand the patient's weakness, mistake or abnormal behaviour, without reprimanding him/her. Moreover, respect the patient's right to choose for him/herself and be responsible of his/her choice. This usually comes after negotiating all the options and giving the patient enough information to make his/her own treatment choice or decision. If patient attends with his/her family: watch family dynamics, and build rapport with the family as well.

Points to remember when building rapport with a patient

- Show interest and respect.
- Show support and care.
- Recognize and respond immediately to verbal and non-verbal cues.
- Balance intimate and professional relationship.
- Be flexible and respect patient autonomy.
- Demonstrate appropriate confidence.
- Do not be judgemental.
- Respect patient confidentiality.

Helpful tips to build effective <u>doctor-patient relationship with children</u>:

- ✓ Direct the conversation to the child, if possible.
- ✓ For very young children, providing them with a distraction or mutual task while talking can be helpful. For example, a toy or the stethoscope.
- ✓ Stay at the same level as the child, verbally and physically.
- ✓ Let the child touch the examination instrument before using it; e.g., the tongue depressor or ear scope or stethoscope.
- ✓ Be honest and tell the child how painful the examination or the treatment is going to be but reassure them that you will stop when you want them to.

Helpful tips to build effective <u>doctor-patient relationship with adolescent</u>:

- ✓ Treat him/her with respect.
- ✓ Appreciate their independency and let him/her feel that he/she is in charge of his/her problem(s).
- ✓ Understand their feelings and needs.
- ✓ Offer your support and that of other healthcare professionals when appropriate.
- ✓ Maintain a good balance between your professional image and your friendly attitude.
- ✓ Anticipate possible common problems, but avoid judgmental attitude and comments.
- ✓ Understand their family dynamics.

Helpful tips to build effective <u>doctor-patient relationship with elderly</u>:

- ✓ Show respect by standing up for him/her.
- ✓ Help him/her to be seated.
- ✓ If necessary, ensure hearing aid or spectacles are available.
- ✓ Talk more slowly and wait for replies.
- ✓ Allow more time; sit face to face with the patient.
- ✓ Do not talk loudly.
- ✓ Do not patronize the patient.
- ✓ Talk about the beautiful 'good old days' and give the patient a chance to talk about them.
- ✓ Show interest and respect to his/her beliefs.
- ✓ Help him/her while undressing and dressing during physical examination.
- ✓ Touch can be reassuring.

Step 4. Empathy

Empathy is a religious and humane value; it is not just a package of skills. Empathy is a response that recognizes or names the patient's feeling and does not in any way criticize it. A physician should accept the patient's feeling even though he/she believes the feeling to be wrong or uncalled for. It is the most effective way a physician can use to show how much he/she cares.

Empathic responses

Approach a patient with the aim of understanding his/her personal experience of the disease or health problem. Respond to a patient's emotion with the acronym **NURSE** (Back et al., 2001).

- **N**= Name the emotion
  "I can see that you are anxious and worried"
  "You seem sad today"
  "You seem stressed today"
- **U**= Understand and acknowledge the patient's suffering
  "I can understand why you feel confused and worried"
  "That must be very difficult for you to cope with."
- **R**= Respect the patient without criticism
  "You're doing great."
- **S**= Support the patient
  Silence can be supportive and touch can be reassuring
  "God help you"
  "We will work together to get through this"
- **E**= Explore and facilitate
  "Tell me about your feeling"
  "How do you fell about …?"

Nonverbal expression of empathy

Simply saying 'sorry' to a terminally ill patient will neither help nor comfort him/her. Nonverbal communication plays an essential role in expressing how dedicated and concerned a physician is about his/her patient's well-being. Below are a few examples.

- Use a sad or sympathetic tone when speaking to a worried/troubled patient dealing with or expressing a health problem.

- Express concern through facial expressions.
- Hold the patient's hand to show compassion.

Non-empathic or distracting comments physicians should avoid

- Interrupting patient's description and changing the topic, e.g. telling the patient, "let us concentrate on your back pain first", while he/she was explaining his/her other associated symptoms, will give the patient the impression that the physician is not listening to his/her main concern.
- Disregarding and underestimating a patient's concern, e.g. when a patient is explaining his/her high level of pain and the physician precipitously says "I know better than you, there's nothing wrong with you and you'll feel better tomorrow" or "The real problem is that your mother spoiled you", are statements that can forever destroy any chance of an efficient doctor-patient relationship.
- Judgmental responses are very wrong, e.g. "You are very obsessional and overreacting to a common and simple problem". Such statements could offend the patient and make him/her feel meaningless.
- Counselling the patient before he/she has finished explaining their problem, e.g. interrupting a patient complaining of backache and telling he/she what needs to do next time to alleviate this kind pain in the future. This could be misinterpreted by the patient as a signal to stop sharing their concern or that the physician wishes to get this visit over and done with quickly.
- Premature reassurance, e.g. a patient tells you that her husband didn't come home last night and you comment, "Don't worry about it, he'll be home tonight." This is interpreted by the patient as the physician is saying, "Don't talk to me about it anymore." A good physician should allow the patient to share some information with him/her, this only strengthens the rapport.
- Asking a series of questions without giving the patient time to answer, e.g. a patient has problems in his/her marriage and the physician starts interrogating, "Do you two talk?", "Do you go out?", "How about his/her mother?". Questions control and guide such conversations without helping the patient appropriately. A good physician should give the patient adequate time to answer questions individually.
- Physicians getting carried away with their own similar experience and explain the story based on a problem being described by the patient. This may make the patient feel that the physician has forgotten to focus on the patient's concern.

Useful tips to help physicians improve empathic responses

With time, a physician will learn to better guess his/her patient's feelings. This insight comes from two major sources:

a. **Listening to your own gut feelings and reactions.** Place yourself mentally in the patient's situation; then imagine what you would do and notice how the situation would make you feel. This is one of the most powerful techniques for generating "intuition" about the patient's

emotions. Alternatively, if you had experienced situations similar to that of the patient, then you can recall and mentally re-create the feelings you had. It is reasonable to assume that the patient may be feeling the same way you did in the same or similar situation.

b. **Listening to and watching the patient.** Hear the patient's words and tone of voice, but, also, observe his/her facial expression and other non-verbal messages. Read "between the lines" and pickup verbal and nonverbal cues.

Common barriers to empathic listening:

- Physician trying to mind read what the patient really thinks. "He probably thinks I'm not a good doctor for saying that".
- Planning what argument or story to give next.
- Physician filters what is being said by the patient to hear only certain topics or fails to hear the patient's critical remarks.
- Judging a statement before it is completed, e.g. "crazy," "boring," "stupid," "immature," "hostile," etc.
- Physician going off on one's own daydreams.
- Physician remembering his/her own personal experiences instead of listening to the patient.
- Drafting your prescription or advice long before the patient has finished telling his/her woes.
- Quickly changing the topic or laughing it off if the topic was not a physical problem.
- Placating the other person by automatically agreeing with everything, e.g. "you're right...of course...I agree...really!".

Truths and myths about physician empathy

Myth	Truth
Patients know that physicians care about them by default.	Patients do not experience the physicians' care and compassion until the physician gives voice to it.
Physician's empathy will not change patients suffering.	Acknowledgement of patient's suffering and allowing him/her to vent, is reassuring, and it improves doctor-patient relationship.

Step 5. Physical examination

Physical exam is gradually being overlooked, and replaced by diagnostic tests, which are easier, and take less time to order. Physical exam, when done well, "earns the trust of the patient, and it also lays the foundation for strong doctor-patient relationship." However, when done poorly, "it does the opposite, it creates mistrust, or even a sense of being disrespected."

In today's medical practice, the cause of the problem is time, or the lack thereof; so, it's no revelation that physical exam falls by the wayside. However, this is to the patient's detriment. Just think about how much an exam costs patients in terms of missed diagnoses, unnecessary tests and complications

from tests (such as reactions to contrast for a CAT scan) that were never indicated.

Physical examination could help a physician detect asymptomatic condition. History and physical examination are the basis of clinical medicine.

Below are a few tips on how to best use physical examination to build a good doctor-patient relationship:

- Perform physical examination gently, in a humane manner.
- Take the patient's permission to examine him/her.
- Inform the patient what is going to be examined and why.
- Break the ice and put the patient at ease.
- Explore minimal body parts as needed (nothing more).
- Prepare the patient for possible pain or embarrassment.
- Apologise for any discomfort which may be caused and any potentially painful or embarrassing examinations.
- Inform patient when the physical examination has finished and thank him/her for his/her cooperation.
- Never ask the patient about any history of physical symptoms while examining him/her.

Practice physical examination to explore how the patient feels

- Exposing the body for physical examination can make the patient more ready to explore his/her emotion.
- Never miss the opportunity of listening to the patient during and after examination.
- Physicians need to pay attention to their verbal and nonverbal communication during physical examination and convey reassuring messages as much as possible. For example, a nonverbal look of concern while listening to the patient's heart beat could scare and lead the patient to assume the physician has heard something wrong.
- Keep eye contact while examining the patient as much as you can.

Practice physical examination to reassure the patient

- If appropriate, smile when you are examining the patient. It is very reassuring.
- If there is no need for examination, at least touch the diseased part of his/her body or take his/her pulse just to make the patient feel that he/she has been examined and cared for.

Practice physical examination to enhance positive messages

- Patients on the examination table feel weak and may be helpless; this makes them more suggestible.
- Remember – the power of consultation and the healing effect of touch.
- A smart physician can take the advantage of this psychological situation for the best benefit of his/her patient and give positive suggestions, e.g. reassuring suggestions or counselling to quit smoking.

Truths and myths about physical examination

Myth	Truth
Physicians believe that physical examination is just for detecting signs and making diagnosis	Physical examination is an opportunity to reassure a patient
Physicians believe that painful or humiliating physical examination is not his/her fault	Smart doctors can make it less painful by simply letting the patient know that the examination might be painful and asking the patient to bear with him/her for a while.

Step 6. Doctor-patient partnership

There is a misassumption that most patients do not want to be involved in the treatment process/options and that clinicians are good judges of their preferences (Elwyn et al., 2003). The days of patients accepting prescriptive and paternalistic advice from their physician are nearing their end. Leave the didactic monologues behind. Partnership with the patient, in their treatment decisions or care, is increasingly advocated because:

- It improves patient compliance.
- It improves patient safety.
- Allows physician to share the load and responsibility with the patient.
- Makes the patient feel that he/she is in control of his/her problem/health.
- Reduces the need for unnecessary interventions, e.g. postoperative analgesia and anxiolytic medications.

How to establish doctor-patient partnership

- Define the problem that requires shared decision.
- Legitimize patient involvement and encourage his/her positive role.
- Discuss management options with the patient.
- Explore patient's ideas and encourage him/her to ask questions.
- Negotiate a mutually acceptable plan with the patient.
- Recognize patient's verbal and nonverbal cues and immediately respond appropriately.
- Frequently take feedback from the patient.
- Give the patient enough time to make his/her own decision.

Partnership barriers

- **Lack of information and a reluctance to share data**: Physicians cannot lay out options and their pros and cons if they do not know them (Elwyn et al., 1999).
- **Time and timing**: It is unusual to take big decisions within one consultation, so the task could be staged. Further discussions are often necessary and the agreed view is that "...sharing a decision is a process not an event."
- **Contextual modifiers**: You need to be sensitive to "contextual" modifiers such as age and educational achievement.
- **Types of decisions**: In instances such as urgent or dangerous medical problems or situations of conflict where patient "demand" is contrary to empirical evidence, different decision-making approaches are needed.

Step 7. Closing

In order to create a lasting impression, at the end of the consultation, a physician must be able to:

1. **Summarize**

- Briefly explain and clarify plan of action.
- Safety nets, explain possible unexpected outcomes, such as: what to do if plan does not work, when and how to seek help.
- Make a contract with the patient, explaining what is expected from him/her and what is expected from the physician in the next visit.

2. **Answer the patient's questions and take feedback**

- The patient should leave knowing that all of their concerns have been addressed. Ask the patient if he/she requires any further clarification, questions answered or other items he/she wishes to be discussed.

3. **Confirm partnership**

- The patient needs to be able to depend on the fact that the physician will be there in the future for them. Therefore, a physician should let the patient know that he/she is there for the patient if he/she needed him/her.

4. **Ensure patient satisfaction**

- Final check that the patient agrees and is comfortable with the set plan.

Step 8. Preparation

As a physician, you must be prepared to treat all your patients. Below are a few tips that can help you:

- **Prepare yourself (Housekeeping)**. Some consultations may result in some negative feelings on the physician. A physician should acknowledge all these feelings and deal with them before seeing the next patient. This means making sure that you do not carry forward remaining feelings from one consultation to the other. Ensuring that you're in the right frame of mind to keep yourself mentally, physically, and psychologically in good nick from one patient to the other, or from one surgery to the next or from one week to the next (Neighbour, 1987).
- **Prepare the environment (the clinic).** This means ensuring the clinic is clean and orderly, ready to receive the next patient.
- **Prepare patient's data.** Before a patient enters the clinic all the data pertaining to him/her should be available, i.e. patient history, test results, etc. If there is any data missing you could ensure it is sorted before the patient enters the clinic. This would save a lot of your time as well as the patient's time.

How to deal with job stress

- **Stress during a consultation with a patient**
  - Think positive, get rid of projection
  - Avoid stereotyping
  - Tensing and stretching muscles

- **Unwind between patients**
  - Cup of coffee
  - Short walking
  - Making a phone call
  - Reading a book
  - Checking for mail
  - Talking to someone
  - Breathing exercise
  - Stretching
- **Long-term stress relief recommendations**
  - Positive thinking
  - Leisure and social activities
  - Group discussion - meetings
  - Continuing Medical Education (CME)
  - Effective time management
  - Physical exercise
  - Stress control techniques: yoga or relaxation

Positive effects of doctor-patient relationship on a patient's care

1. Reassurance
2. Compliance
3. Less doctor shopping
4. Decreased errors and medical litigation
5. Improved quality of healthcare

DISCUSSION

- Patients of physicians who encourage them to participate more actively in the medical encounter and in treatment decisions enjoy more favourable outcomes both physiologically and functionally (Tuckett et al., 1985).
- When the patient and physician agree on the nature of the problem and the proposed solution, (i.e. diagnosis and treatment), the outcome is enhanced.
- Women with breast cancer who were seen by surgeons offering patients a choice between mastectomy and lumpectomy suffered less anxiety and depression than patients seen by surgeons favouring either one or the other (Lee et al., 2002).

Medical decision making preferences of 999 women with breast cancer (Lee et al., 2002)

Theoretical model	Decision making process	%
Paternalistic	Physician makes decisions	18
Physician as agent	Physician makes decisions after considering patient's input	17
Shared decision making	Physician and patient make decision together	44
Informed decision making	Patient makes decisions after considering physician's input	14
Consumerism	Patient makes decisions	9

Doctor-patient partnership agreement

To apply doctor-patient partnership more formally in patients with chronic diseases, you may sign a contract or an agreement with the patient, example below:

Doctor-Patient Partnership Agreement

OBJECTIVE

To better manage your hypertension through a doctor-patient partnership and goal setting.

REASON

Medical research and clinical experience have shown that optimal management of hypertension significantly reduces the known complications of this disease, including heart attack, kidney failure and stroke.

EXPECTATIONS

You can expect your physician to provide the following services, which are an essential part of hypertension management.

Office visits - .....

Monitoring - ..... Annual screening - .....

PERSONAL GOALS

Weight/Body Mass Index: Current:_____ /_____ Ideal:____ / ____

Blood pressure (< 140/90 mm/Hg): Current:_____Goal:_____

Total cholesterol (< 200 mg/dl): Current:_____Goal: LDL (< 100 mg/dl):

Current:_____Goal:_____

YOUR RESPONSIBILITIES

- Schedule follow-up appointments every three months or as indicated by your doctor.
- Monitor blood pressure at home at the agreed testing frequency.
- Work towards attaining the personal goals noted above.

Patient signature: _____Date: _____

Physician signature:_____Date: _____

RECOMMENDATION

Demonstrate to your patients you understand their situations and feelings by showing empathy during consultation. Empathetic communication is one of the most valued modalities of physician which help to ensure a trusting relationship between a physician and his/her patients.

Physician counselling and listening skills could be enhanced by using a simple five step process to gather information about the context of the patient's visit by asking the patient: 1) What is happening in your life? 2) What are you feelings about that (or how does it distress you)? 3) What is it about the situation you find upsetting you most? And 4) How are you managing that? Then, show understanding by observing: 5) "I can perceive that must be very challenging for you." This method is identified by the abbreviation BATHE (which stands for background, affect, trouble, handling, and empathy).

Attentive physicians, who maintain eye contact and provide positive cues, encourage patients to open up to them easily.

SELF-ASSESSMENT EXERCISES

Exercise 1

Role-play: With two colleagues, take turns being: (1) the doctor giving nonverbal facilitation responses, (2) the patient pretending to have problems and (3) the observer giving feedback using a 5-point scale. The observer must rate every response given by the doctor. Stop the interaction after 4 or 5 responses have been rated. All three can discuss the good responses and how a certain response could have been more effective.

	Nonverbal Facilitation	1	2	3	4	5
1	Eye contact					
2	Silence					
3	Paralanguage					
4	Facial expression					
5	Touch					
6	Posture & Gestures					

Exercise 2

Role-play: With two colleagues, take turns being: (1) the doctor giving **verbal & nonverbal facilitation** responses, (2) the patient pretending to have problems and (3) the observer giving feedback using a 5-point scale. The observer must rate every response given by the doctor. Stop the interaction after 4 or 5 responses have been rated. All three can discuss the good responses and a how certain response could have been more effective.

	Verbal & Nonverbal Facilitation	1	2	3	4	5
1	Questioning					
2	Probing					
3	Confrontation					
4	Paraphrasing					
5	Verbal mirroring					
6	Interpretation					
7	Reflecting					
8	Summarizing					
9	Eye contact					
10	Silence					
11	Paralanguage					
12	Facial expression					
13	Touch					
14	Posture & Gestures					

Exercise 3

Skills	How
Show interest & respect	
Recognize verbal and non-verbal cues	
Immediately respond to patient's cues	
Show support and care	
Balance between intimate & professional relationship	
Be flexible & respect patient autonomy	
Demonstrate appropriate confidence	
Control your judgmental attitude	
Respect patient confidentiality	
If patient attends with his/her family: watch family dynamic, and build rapport with the family	

(Lang & Tennessee, 2002)

Exercise 4

Discuss the skills needed by physicians to maintain effective doctor-patient relationship while conducting physical examination

Case 1

Examination of a child

- .....
- .....
- .....
- .....
- .....

Case 2

Examination of an elderly patient

- .....

- .....
- .....
- .....
- .....

Case 3
Examination of a patient of different gender than the doctor

- .....
- .....
- .....
- .....
- .....

Case 4
Examination of an anxious patient

- .....
- .....
- .....
- .....
- .....

Case 5
Examination of a patient in pain

- .....
- .....
- .....
- .....
- .....

Exercise 5

From what we have discussed in the previous chapters, write 30 strategies, verbal statements or nonverbal cues, which you may use during a consultation that would positively affect your relationship with your patient.

1	16
2	17
3	18
4	19
5	20
6	21
7	22
8	23
9	24
10	25
11	26
12	27
13	28
14	29
15	30

NB: Remember to add feelings to your words

Exercise 6

Role-play: With two colleagues, take turns being: (1) the doctor giving **empathic responses**, (2) the patient pretending to have a variety of problems and (3) the observer giving feedback to the empathizer using a 5-point empathy scale. The observer must rate every response given by the doctor. Stop the interaction after 4 or 5 empathic responses have been rated. All three can discuss the good responses and how a certain response could have been more effective.

	Empathic Responses	1	2	3	4	5
N	Naming the emotion					
U	Understanding & acknowledgement of suffering					
R	Respect and no criticism					
S	Support & silence					
E	Exploring and facilitating					

Exercise 7

How to share decision-making with patients

Steps	How
1. Define the problem that requires shared decision	
2. Legitimize patient involvement and encourage his positive role	
3. Outline the options: Describe one or more treatment options and, if relevant, the consequences of no treatment	
4. Explore patient's ideas and encourage questions	
5. Negotiate mutually acceptable plan	
6. Recognize patient's verbal and non-verbal cues & respond to his cues	
7. Frequently take feed back	
8. Give patient enough time to make his decision	

Exercise 8

Discuss the below rapport building skills and their barriers

Skills	Barriers
1. Establish the relationship	
2. Facilitation	
3. Building rapport	
4. Empathy	
5. Making use of physical examination	
6. Partnership	
7. Closing & maintaining the relationship	
8. Preparation	

Discuss possible strategies that would help you to overcome these barriers

_____

_____

_____

_____

Exercise 9
Concentrate entirely on the decision-making aspect of the below consultations:

Case scenario 1
1. Atrial fibrillation
Patient wants to know about the pros and cons of warfarin and aspirin for prevention of stroke

Comments:
_____

_____

_____

Case scenario 2
2. Benign prostatic hypertrophy
Patient wants to know more about the typical options that face a man who is told that he has "prostatism," with no other risk factors

Comments:
_____

_____

_____

Case scenario 3
3. Menopausal symptoms
Patient undecided about hormone replacement therapy and anxious about the risk of breast cancer

Comments:
_____

_____

_____

FURTHER READING

Morgan M (2003). The Doctor-Patient relationship. In: Scambler G, editor, Sociology as applied to Medicine. 5th ed. Saunders (W.B.) Co Ltd (Elsevier Health Sciences). pp 55-70
http://faculty.ksu.edu.sa/nadalyousefi/communication%20skills/The%20Doctor%E2%80%93Patient.pdf
العلاقة بين الطبيب و المريض (من كتاب الأسس العلمية للاستشارة الطبية)

BREAKING BAD NEWS

INTRODUCTION

Bad news is defined as any information which adversely and seriously affects an individual's view of their future; whether news is bad or not can only be in the eye of the beholder (Buckman, 1992). Physicians need to develop the skill of breaking bad news, as they will do it time and time again during their career. During the past medical training, breaking bad news was not considered an essential skill a physician needed to acquire and consequently, little attention was focused on the topic during training period. However, this has of course changed over the recent years and it has now become a primary part of medical school curriculum. This is because studies have now shown that poor communication, especially with patients diagnosed with life alerting diseases such as cancer, was associated with worse clinical and psychosocial outcomes, including worse pain control, worse adherence to treatment, confusion over prognosis and dissatisfaction at not being involved in decision making (Hanratty et al., 2012).

The information provided in this chapter can be used not only as a model for communicating bad news to patients but it should also be implemented as a model for communicating information to all patients.

TRAINING OBJECTIVES

- Improve physicians skills in communicating bad news
- Understand the importance of communicating bad news efficiently
- Understand how to relate the protocol to communicate any news

BREAKING BAD NEWS

Physicians need to individualize their manner of breaking bad news centred on how serious the diagnosis is as well as the patient's desires and needs. To break bad news, the physician must understand and master the skills and ability required to recognise and respond to patient's emotions, support them deal with the stress that the bad news creates while still being able to involve the patient in any decisions while maintaining hope, where there may be little.

Many physicians find it difficult to convey bad news to their patients, especially when it involves a life-threatening illness. Besides the verbal element of actually conveying bad news, breaking bad news also requires a set of other skills; such as: acknowledging and responding to the emotional reactions of patients, getting the patient involved in the decision-making process, handling the stress generated by patients' expectations for treatment/cure, participation of multiple family members, and the perplexity of how to give hope when the circumstances are desolate. However, delivering bad news in a direct and caring way may improve the patient's as well as family's ability to plan and cope, encourage realist goals and self-reliance, support the patient emotionally, strengthen doctor-patient relationship and stimulate collaboration among the

patient, family, physicians, and other professionals which would be involved in the treatment or management process.

Described below is the recommended six-step protocol "SPIKES" which has been shown to improve clinicians' confidence when used to break bad news to their patients. It is a gradual and soft method of breaking bad news to seriously ill patients.

It is important that a physician asks, early in clinical relation, about his/her patent's general preference(s) for the handling of medical information and decision making before significant information needs to be shared.

6-STEP PROTOCOL - SPIKES

SPIKES	6-step protocol to clarify diagnosis and prognosis
Setting	**Getting started** • Prepare yourself, the environment and patient's data readily available. • Arrange for some privacy, in an environment that is favourable for effective communication. • Involve significant others by inviting spouse, relative, friend, etc. appropriately. • Sit down. • Make connection and establish rapport with the patient. • Manage time constraints and avoid interruptions.
Perception	**What does the patient know?** • Introduce yourself properly. • Spend a few minutes establishing rapport. • Determine what the patient knows about his/her medical history and assess what he/she suspects. • Carefully listen to the patient's level of comprehension. • Accept denial but do not confront at this stage because denial is a healthy defence mechanism.
Invitation	**How much does the patient want to know?** • Await invitation from the patient to give information. • Ask patient if he/she wishes to know the details of the medical condition and/or treatment as well as how much he/she wishes to know. • Accept patient's right **not** to know. • Offer to answer questions later if he/she wishes.
Knowledge	**Sharing the information** • Give medical facts. • Use language that is understandable by the patient. • Take into account the patient's educational level, socio-cultural background, current emotional state. • Share the information gradually, in small chunks and check understanding.

	• Check whether the patient understood what you said • Respond to the patient's reactions as they occur • Give any positive aspects first e.g.: Cancer has not spread to lymph nodes, highly responsive to therapy, treatment available locally etc. • Give facts accurately about treatment options, prognosis, costs etc. • Warning shots (Say it, and then stop speaking) • Deliver the information in a sensitive but straightforward manner
Emotion	**Responding to feelings** • Explore emotions and sympathize • Prepare to give an empathetic response: 1. Identify emotion expressed by the patient (sadness, silence, shock etc.) 2. Identify cause/source of emotion 3. Give the patient time to express his/her feelings, then respond in a way that demonstrates you have recognized connection between 1 and 2. ➢ "I imagine this is difficult news..." ➢ "You appear to be angry. Can you tell me what you are feeling?" ➢ "Does this news frighten you?" ➢ "Tell me more about how you are feeling about what I just said." ➢ "What worries you most?" "What does this news mean to you?" ➢ "I wish the news were different." ➢ "I'll try to help you." ➢ "Is there anyone you would like me to call? - Remind them that their responses are normal
Strategy	**Planning and follow-up** • Close the interview • Ask whether they want something else clarified. • Establish a plan for the next steps. 1. Gathering additional information 2. Performing further tests. 3. Treat current symptoms. • Reassure the patient and family that you will be actively engaged in an ongoing plan to help. • Ensure that the patient will be safe when he/she leaves.

(Baile et al., 2000)

1. Getting started

Setting

To get started, as physician, you must first know and understand what you will be discussing with the patient. Ensure that your medical facts about the illness are up-to-date. Avoid interruptions and allocate adequate time for discussion, arrange to hold telephone calls and pages. Ask your patient who else would he/she like to have present for the discussion, such as: family, spouse, friend, etc.

2. What does the patient know?

Perception

Introduce yourself and spend a few minutes building rapport with the patient and any other person present with him/her. Then once you feel the patient is at ease, initiate the discussion by asking the patient what he/she knows about his/her medical history to assess the patient's previous knowledge about information given and/or recent investigations. This could be done through a series of questions, such as:

- What do you know about your medical history, condition or any procedures that you have had?
- Do you know the cause of your medical symptoms?
- What are your worries about your illness or symptoms?
- Do you think these symptoms are a result of something serious?
- What did the other physicians inform you about your health?

This would allow you to determine the patient's level of understanding, discover what has happened since his/her last visit and how to proceed. Sometimes a patient (or a guardian – mother, father, aunt, grandmother, etc.- if the patient is a child) will fall silent and seem completely unprepared or unable to respond. You can try to encourage discussion by clarifying the patient's understanding about his/her health using the results of recent investigations/studies conducted. However, if all your attempts to stimulate discussion are unsuccessful and the patient remains silent, or if it appears that the patient requires more support, such as the presence of a family member or others on whom he/she relies on; it may be better to reschedule the meeting for another time. Denial is a healthy defence mechanism, therefore, do not confront denial at this stage.

3. How much does the patient want to know?

Invitation

Everyone handles information differently, depending on their race, society and culture, level of education, religion and socioeconomic class. Ask your patient how he/she would prefer to receive information about their health condition. This could be either shared directly to the patient alone, in the presence of someone else (family member, friend, etc.), or through a person who he/she has designated to receive the information on his/her behalf. You can determine this by using questions such as:

- In the event that these symptoms turn into something serious, would you like to know?
- Do you want to know the full details of your condition? If not, can you elect somebody else you would prefer I talk to?
- Are you ready to go over the results of the recent investigations now and listen to what is exactly wrong?

It is important that the physician maintains eye contact with the patient to explore the patients concerns and expectations as well as interpret the patient's nonverbal signals (face/body language).

4. Sharing information

Knowledge

When conveying your message, first try to see the world through the patient's eyes; how would you feel if you were the patient? Convey the information in a sensitive yet straightforward manner. Start communicating the bad news using a warning shot, start with an opening sentence and then stop, this will prepare the patient for what is to come. Avoid delivering all of the information in one chunk, instead use staging to categorise the information to be given and gradual delivery of the message in small chunks. Watch the pace, pause frequently and check repeatedly for patient's understanding and feelings as you proceed; do this in subsequent visits as well. Give the patient time to process it all and ask questions about points he/she needs clarified. Give basic information, simply and honestly; repeat important points if needed. Do not use technical jargon or euphemisms; ensure you use simple language that is easy to understand. Below is an example of how to use warning shots, staging and finally break bad news.

- **Doctor:** (Warning shot) I'm afraid the news isn't very good.
- **Patient:** What do you mean?
- **Doctor:** (Staging) The bone marrow is not making the right type of blood cells.
- Patient remains silent but looks at doctor enquiringly.
- **Doctor:** (Staging) There are underlying problems with the bone marrow **Patient:** So what is it?
- **Doctor:** (Breaking the bad news) it's a type of leukaemia.

Use silence and body language as tools to facilitate the discussion. Try recognising the feelings that lie behind the stunned silence. Avoid minimizing the severity of the situation; a good-hearted attempt to "mitigate the blow" may lead to ambiguity and misunderstanding. You might choose to break bad news by using comments such as:

- Unfortunately, I'm afraid the news is not good. The test results indicate you have leukaemia.
- The test results are in and it's not what we had expected: it's pneumonia.
- I'm afraid I have bad news for you. The results show that you have HIV.

Use safety netting (checking you have not missed anything and preparing a contingency plan) to judge how much further information the patient wants and in what way it can be usefully communicated. Try not to use the phrase "I'm sorry" because this may be interpreted to imply that you as a physician is responsible for the situation at hand. Furthermore, this may also be misunderstood as pity or coldness, therefore, if you use the phrase modify it to show empathy.

5. Responding to feelings

Emotions

Different people deal or respond to bad news differently; some cry, get angry, feel sad or anxious, etc. Parents may become very emotional when thinking about actually telling their child the diagnosis. Outbursts of strong emotion

make many physicians uncomfortable. The physician must acknowledge, recognise and be empathic about the patient's pain, grief or bewilderment, for example by saying,

- "You seem to be angry. Can you tell me what you are feeling?"
- "This must come as an awful shock to you."
- "Are you frightened by this news?"
- "Is there anyone you would like for me to call?"
- "I'll help you tell your daughter."

Let the patient know it is alright to cry and express their feelings, if he/she needs too. Try to break down devastating feelings into manageable concerns, prioritising and distinguishing the fixable from the unfixable. Be aware of unshared meanings, for example, what cancer means to a patient could be different from what it actually means medically to a physician. Hold the patient's hand, if appropriate. Offer a drink of water, cup of tea or anything else that might be soothing. Assess and respond to the patient's as well as the family's emotional reaction. Give realistic hope including both worst and best scenarios (preparing for the worst and hoping for the best). Highlight any positives help e.g. pain relief. Offer continuing support/ practical advice.

When sharing bad news to a patient, a physician must remember that he/she is also human with emotions and feelings who is probably experiencing/ experienced a similar situation him/herself. Therefore, a physician must remember to do "housekeeping". Housekeeping is when a physician reviews his/her own feelings, such as dealing with death or dying of a loved one or patient, which is a major cause of stress for medical staff. It is acceptable for a physician to shed a tear with his/her patients: it seems that patients gain support in dealing with bad news when they perceive their informant is also distressed and concerned. The professional statement of "not to get involved" has encouraged emotional suppression within the profession that prevents the doctor showing distress which could be harmful for the physician in the long run.

6. Planning and follow-up

Strategy

At this stage of this 6-step protocol, the physician must be able to summarise all that's been said and plan for the next steps such as: gathering additional information or performing further tests, etc. The physician here could also:

- Help parents tell their child about their illness and what treatment would be right for them.
- Arrange for appropriate referrals.
- Explain plans for additional treatment.
- Setup follow-up visit.
- Discuss potential sources of emotional and practical support, e.g. family, significant others, friends, etc.
- Discuss sources of support for an ill child's siblings.

It is supportive to reassure the patient and family members that the physician will not abandon them and that he/she will be there, actively engaged in the

ongoing plan to help. Provide a telephone number that the patient and family members can use to reach the physician in order to have answers to any additional question.

Last but not least, the physician must ensure that the patient will be safe when he/she leaves the clinic/hospital. Ensure the patient will be able to drive home alone, whether the patient is distraught, feeling desperate or suicidal?

HOW TO DEAL WITH FAMILY THAT SAY "DON'T TELL"

Family members, at times, ask the physician not to tell the patient the diagnosis or other critical information. However, even though it is the physician's legal obligation to obtain informed consent from the patient stating his/her decision to not know and have someone else receive any bad news, an effective beneficial relationship requires a friendly alliance with the family. Instead of opposing their request with "I must tell the patient," request them to explain why they do not want to tell the patient, what it is they are afraid will be said to the patient and what was their experience in regards to bad news in the past. A physician must also inquire whether there is a personal, cultural, or religious context to family members' concern. Recommend to the family members that everyone (including the physician) all go to the patient together to ask how much he/she wants to know about his/her health and what questions there might be. Such situations may require significant negotiation. In particularly difficult cases, support from the institution ethics committee may be very helpful. Eventually, it could be decided, after discussion with the patient, which specifics of diagnosis and prognosis and treatment decision will be discussed only to the family. However, unless the patient has previously indicated that he/she wants no information, concealing diagnosis or important information about prognosis or treatment from the patient is neither ethical nor legally acceptable. Physicians do not need to feel forced to practice in a manner that compromises care or feels unethical. If the physician and the family cannot come to agreement, the physician may choose to withdraw from the case and transfer care to another physician.

When dealing with a pediatric patient, the parents may not wish to inform the child about the illness. This caring instinct is comprehensible, but it may ultimately be problematic because, as the child undergoes treatment and procedures, he/she will perceive there is a problem. When this happens, it could make the child feel distrustful and misled. To avoid such situations, a better approach would be to help the parents understand this possibilty is likely to occur. To help the parents in break bad news to a child, get a child psychology staff member available along with the medical team to communicate important medical information to the child at an age-appropriate level.

There are several ethnic and cultural differences in the preferred handling of information. While knowledge of such differences is useful as background, international conclusions about them rarely help with decision making for an individual. A patient should be asked about his/her general preferences for the handling of medical information and decision making early in the clinical

relationship before important information needs to be conveyed. This will help the physician avoid making a mistake in this regard.

SUMMARY

When breaking bad news is challenging with or without training, however, physicians can improve patient satisfaction as well as their own satisfaction by using the following simple memory aid, ABCDE, to provide courage and healing to patients receiving bad news:

- **Advance preparation**: Adequate time and privacy must be arranged, medical facts ought to be confirmed, relevant clinical data should be reviewed, and the physician must emotionally prepare him/herself for the encounter.
- **Build a therapeutic relationship**: Patient preferences regarding the disclosure of bad news must be established early on in clinical relationship.
- **Communicate well:** Determine the patient's knowledge and understanding of the situation, proceed at the patient's pace, avoid medical jargon or euphemisms, allow for silence and tears, and answer questions.
- **Deal with patient and family reactions:** Assess and respond to emotional reactions and empathise with the patient.
- **Encourage/validate emotions:** Offer realistic hope based on the patient's goals and deal with your own needs.

Don'ts

- Do not make assumptions about:
  - ✓ The impact of the news on the patient
  - ✓ The patient's readiness to hear the news
  - ✓ Who else should be present when breaking bad news
  - ✓ Patient's understanding
- Do not give the patient too much information at one time.
- Do not give inappropriate reassurances/false hope.
- Do not hurry or rush the patient.
- Do not use medical jargon, e.g. ulcer, etc.
- Do not break the bad news to relatives before telling the patient unless this has already been agreed upon in early clinical relationship or when there is a justifiable reason.
- Do not collude with the family.

REASSURANCE SKILLS

Supportive comments are not enough for effective reassurance. Credibility is not just a package of skills. Credibility is the reflection of our beliefs and values. Here are a few points we shall discuss to enhance reassurance skills

Doctor as a drug

The pharmacology of doctor-patient relationship can be therapeutic if the physician uses his/her authority for reassurance, and it can be toxic if it is used in high-doses and it can also cause patient dependency (Balint, 1957).

Art of reassurance

1. **Effective doctor-patient relationship**
    a. **Credibility and trust:** Doctor needs to gain the trust of his/her patient in order to be effective in his/her reassurance. And the patient needs to look up to his/her credible physician in order to believe him/her.
    b. **Caring support:** This can be done verbally by using positive comments, e.g. "it is your right to feel this way", "I will do my best to deal with this problem", "I am your doctor and helping you is my duty". This can also be done nonverbally through touch (if appropriate), e.g. holding the patient's hand, helping the patient before and after physical examination.
    c. **Accessibility:** It is very important, for effective reassurance, to have reasonable access to the doctor if a patient need's him/her; otherwise the patient may feel neglected and face his/her problem(s) alone. This accessibility can be through telephone consultation, if needed, or in a following appointment.
2. **Exploration and good listening tips**
    a. **Fears:** Encourage the patient to talk about his/her fears without interruption or judgment.
    b. **Hidden agenda:** Try to be sensitive to any verbal or nonverbal cues in order to ask for any possible hidden agenda.
3. **Physical examination**
    a. There is no effective reassurance without physical examination. Doctor will lose credibility if he/she tells the *patient "you are ok" "there is nothing to worry about"* without doing a physical examination.
    b. Remember the magical effect of touch and exhibition of concern.
4. **Explaining and giving reassuring information.**
    a. Avoid jargon, when naming the diagnosis.
    b. Explain how common it is.
    c. Answering patient's questions and uncertainty.
    d. Discuss prognosis in a positive objective approach.
    e. Discuss the available treatment options.
    f. Empowering patients through positive thinking and faith.
5. **Offer appropriate management option (care if you cannot cure).**
    a. Treat the disease.
    b. Control the symptoms.
    c. Support psychotherapy or counselling if needed and use referral when appropriate.

SELF-ASSESSMENT EXERCISES

Exercise 1

Case scenario 1

Mrs. Badria aged 39 years, pregnant for the first time. At 30 weeks' gestation, you diagnosed IUFD.

Q1. Speculate how this patient may feel.

_____

_____

_____

_____

Q2. Discuss possible strategies in dealing with this patient.

_____

_____

_____

_____

Q3. Suggest some specific verbal and nonverbal skills.

_____

_____

_____

_____

Case scenario 2

Mr. Badr aged 39 years; investigations confirmed that he has AIDS

Q1. Speculate possible problems this consultation may raise.

_____

_____

_____

Q2. Discuss possible strategies in dealing with this patient.

Q3. Suggest some specific verbal and nonverbal skills.

Case scenario 3
Mohammed is an 8-year-old lovely boy, he needs heart transplantation

Q1. Speculate possible problems in communicating with his parents.

Q2. Discuss possible strategies in dealing these problems.

Q3. Suggest some specific verbal and nonverbal skills.

_____

_____

_____

_____

_____

_____

Case scenario 4

Mrs. Badria, a 32-year-old lady with frequent somatic symptoms attends with a history of headache for the past 5 years. It appears to be tension headaches. She asks for a CT scan.

Q1. Discuss the patient's feelings.

_____

_____

_____

_____

Q2. How would you proceed?

_____

_____

_____

_____

Case scenario 5

Mrs. Salma is a 40-year old lady. She has a large uterine fibroid, attending today to discuss with you the hysterectomy operation.

Q1. Discuss the patient's feelings.

_____

_____

Q2. How would you proceed?

Exercise 2

Write 30 strategies that may help physicians to increase their **credibility** and be more effective in reassurance:

Verbal communication skills

Nonverbal communication skills

Clinical competence

Professionalism

Dynamism

FURTHER READING

مهارات تبليغ الخبر السيء (من كتاب الأسس العلمية للاستشارة الطبية)

CONSULTATION MODELS

INTRODUCTION

Consultation models help add structure to a consultation, averting it from going everywhere and deteriorating into a chaotic mess. Consultation models allow us to understand the patient's perspective which consequently leads to better doctor-patient understanding that ultimately results in better harmony and less patient complaints.

During the last 30 years, many consultation models have been developed. These models vary in their content, psychometric properties and usability but they all have three points in common: information input, information processor, and output of results. There is little agreement on the ideal model, as no single model covers all consultation tasks and skills. Listed below are different consultation models generated through the past decades:

1. Balint (pronounced Bay-lint) (1957)
2. Transactional Analysis (TA) (1964)
3. The Triaxial Model (1972)
4. Health Belief Model (1975)
5. Six Category Intervention Analysis (1976)
6. Byrne and Long (1976)
7. Stott and Davis (1979)
8. Helman's 'Folk-Model' (1981)
9. Pendleton, Schofield, Tate and Havelock (1984)
10. McWhinney's Disease-Illness model (1984)
11. Problem Based Interviewing (1985)
12. Neighbour (1987)
13. The Three Function Model (1990)
14. Tate's Model (1994)
15. The Calgary Cambridge Model (1996)
16. Neurolinguistic Programming (NLP), (2002)
17. Narrative Medicine (2002)
18. BARD Model (2002)

In this chapter, we present only a few of the most commonly used models with brief comments and discussion.

TRAINING OBJECTIVES

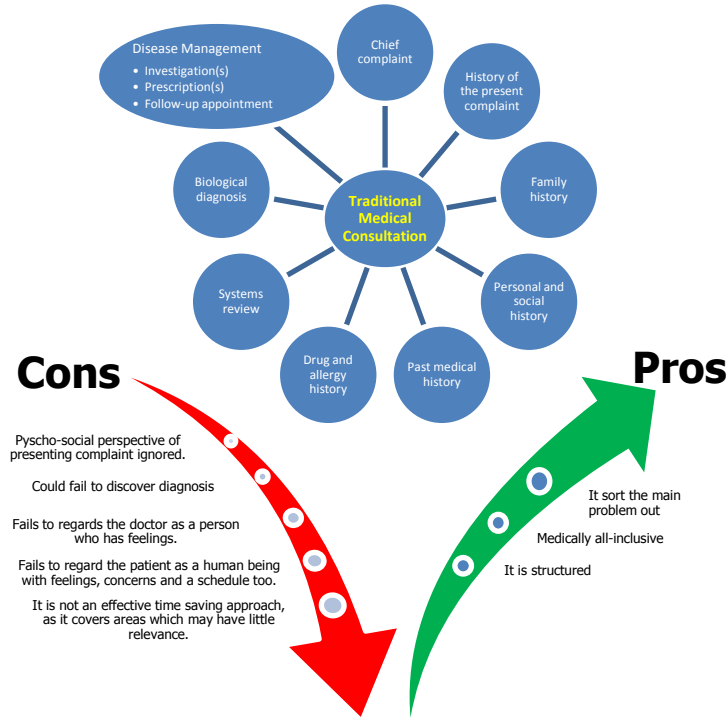
- Familiarise you with the different consultation models (past and present).
- Help you build consultation model that best fits your professional needs.

CONSULTATION MODELS

Traditional Medical Consultation Model

This type of model is purely basic approach to managing patients, where the disease and diagnostic process are of principal importance. It does not consider the patient's thoughts or feelings, neither does it consider what is happening in their lives. It's purely a functional model to do the main job of sorting out the

problem, not necessarily the patient. Basically this model is not interested in the patient's illness; it's only interested in sorting out the problem.

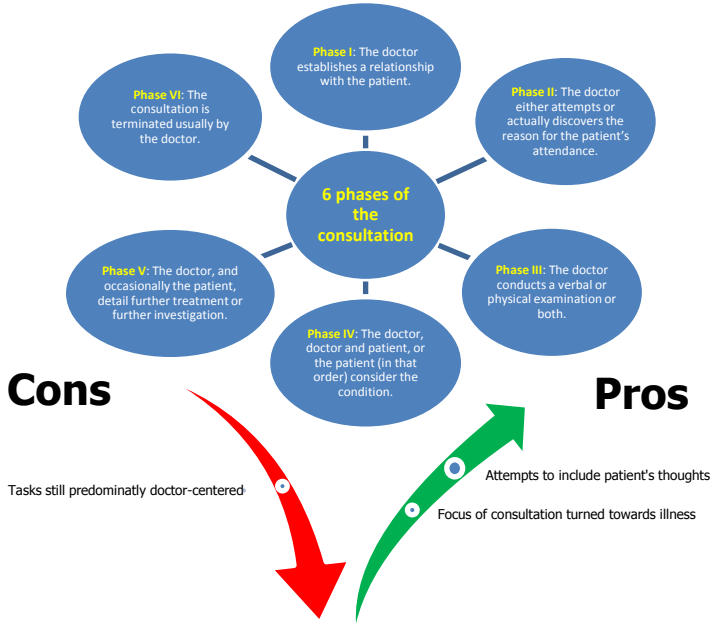


Byrne & Long Model, 1976

Byrne and Long analysed 2,500 audio-tape consultations from over 100 GPs in New Zealand and the UK. They identified styles of consultations:

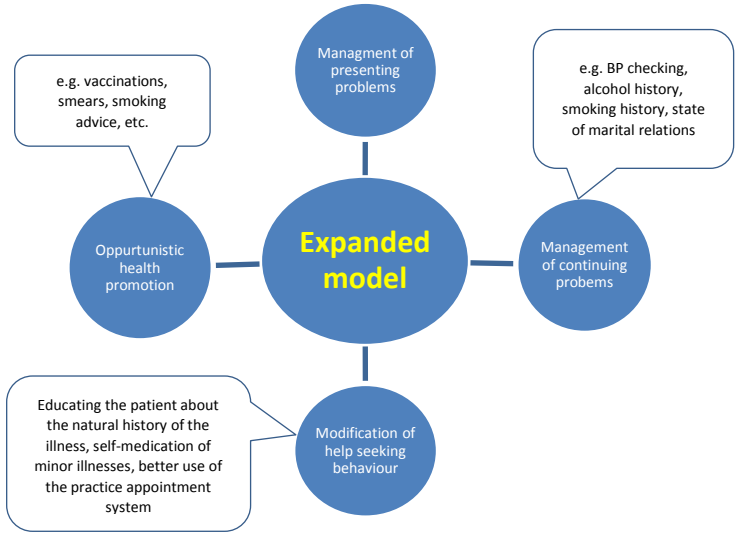
- **Doctor-centred consultation**: The doctor was more likely to make the decision for the patient and instruct him to seek some service.
- **Patient-centred consultation**: The doctor was more likely to seek the patient's views and permit him/her to make his/her own decision concerning the outcome.
- **Negative behaviour**: Failure to explore the real reason of the patient's problem by not listening, evading patient's questions, etc.

Their model was the first consultation to consider specifically the task of introducing and concluding the consultation. They formulated a framework of six tasks or 'fields to be covered' for any consultation.



Expanded Model (Stott & Davis, 1979)

The exceptional potential in each consultation suggests that four areas can be systematically explored each time a patient consults. (Stott & Davis, 1979)



Example: Mrs. Salma is a 70-year-old lady with DM. She sends her daughter, who requests a repeat prescription of glibenclamide and paracetamol for her arthritis. You noticed that Mrs. Salma did not come to the clinic since last year, what do you do?

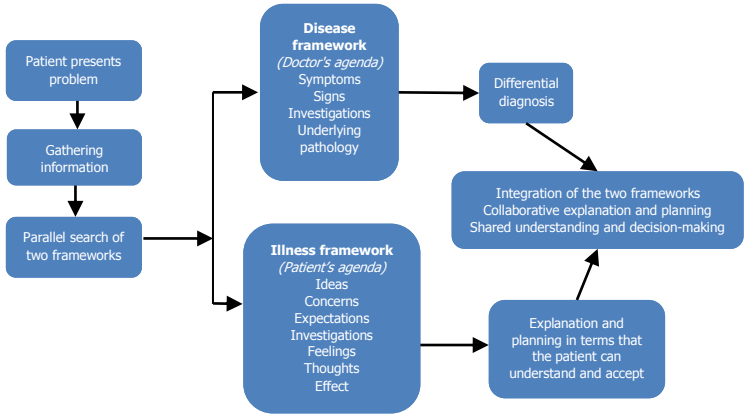
1. What are the presenting problems? • Repeat prescription • Possible elderly neglect	**2. What are the continuous problems?** • DM • Arthritis
3. Is there any help seeking behaviour that needs modification? • No compliance with appointment	**4. What is the appropriate screening and health promotion?** • Hearing and vision, renal disease. • Cognitive impairment. • Pneumococcal vaccine, influenza vaccine, etc.

Examples of help seeking behaviour that need modifications:

- **Denial:** Some patients unconsciously forget about their health problems and act as if they did not exist. This psychological defence mechanism leads to poor compliance with management plan.
- **Displacement:** Some patients use another psychological defence mechanism called displacement, instead of complaining directly of the real reason for their problem, e.g. embarrassing physical, psychological or social problems, they bring a ticket to their physician like: backache or headache, or they may bring their children, complaining of a variety of illogical problems (Balint, 1957).

Disease-Illness Model (McWhinney, 1984)

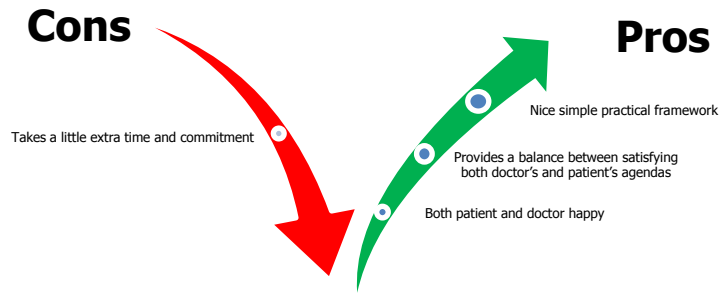
The Disease-illness Model attempts to provide a practical way of transforming clinical method to a more 'patient-centred clinical interviewing' by putting together two approaches: the patient's experience of the illness and the traditional biomedical history consultation. This model helps you realise that disease is the cause of sickness whereas illness is the unique experience of the sickness.



- This model is patient-centred.
- It emphasizes the importance of exploring the patient's perspective of his/her illness (ideas, concerns, feelings, thoughts and the effect of the problem).
- Diagnosis depends on objective and subjective data gathering (doctor impression and patient feelings) as well as psychosocial data.

Discussion

- Organic disease fails to explain many patients' problems: About a third of the patients who present to the Emergency Department with chest pain have a current psychiatric disorder and that psychiatric disorders among chest pain patients are associated with a high rate of Emergency Department utilization for chest pain evaluations (Wulsin & Yingling, 1991).
- Eliciting patient beliefs about their illness is the key to enabling the patient to understand and recall information.
- Undiscovered discordance between the health beliefs of patients and physicians can lead to a problem in patient's satisfaction as well as patient's compliance and outcome (Wulsin & Yingling, 1991).

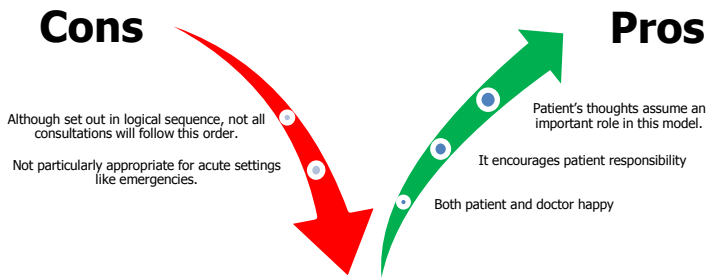


7-Task Model (Pendleton, 1984)

In Pendleton's model, the personal and psychological aspects of the illness are further developed. The model describes 7 tasks: the first 5 tasks are concerned with what the doctor needs to achieve and the final two deal with the use of time/resources and creating an effective relationship.

Tasks	Details
The First Task To understand the reasons for patient attendance	• The patient's problem: • It's nature & history • It's aetiology • It's effects • The patient perspective: • Personal and social circumstances • Ideas and values about health • Ideas about the problem • Concerns about the problem • Expectations

The Second Task To achieve a shared understanding	• Continuing problems • At-risk factors
The Third Task To choose an appropriate action for each problem	• Options and implications
The Fourth Task To enable the patient to manage the problem	• Discuss the patient ability • Agree about responsibilities • Agree about targets
The Fifth Task To consider other problems	• Not yet presented • Continuing problems • At-risk factors
The Sixth Task To use time appropriately	• In the consultation • In the long term
The Seventh Task To establish or maintain the relationship	• Welcoming (positive first impression) • Closing (positive last impression)



Inner Consultation (Neighbour, 1987)

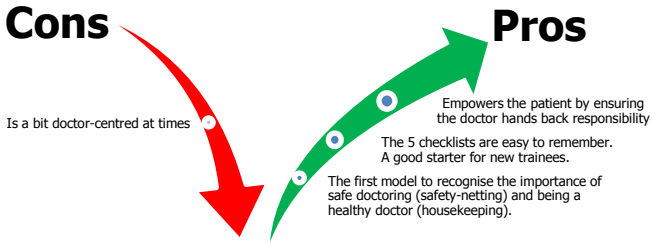
Neighbour's 5-stage consultation model

- **Connecting:** Establishing relationship with the patient by viewing the world from his/her perspective.
- **Summarizing:** Determining why the patient has come using eliciting skills to discover their ideas, concerns, expectations and summarising back to the patient.
- **Handing-over:** Sharing vital and important information, in addition to, returning control and responsibility to the patient by involving him/her in management/decision-making process.
- **Safety-netting:** Anticipatory care, by checking you have not missed anything and making a contingency plan. Consider 'What if?' scenarios.
- **Housekeeping:** Checking and dealing with your own emotions and stress.

The Doctor's Two Heads

Neighbour describes the two different heads of a doctor during consultation. Physicians need to find a way to balance the two heads together for a smooth and fruitful consultation.

1. One is entitled the *Organiser* which is the doctor-centred head busy trying to:
   - manage the organisation of the consultation,
   - asking questions and deciding to examine
   - planning and negotiating clinical management
   - time keeping – i.e. slowing down and speeding up consultations
   - and making records.
2. The other head is called the *Responder* which is the patient-centred head trying to make sure he/she is:
   - Being attentive by listening to the patient properly
   - Taking time to think and process information
   - Creating and testing ideas
   - Being empathic towards the patient.



Three-Function Model (Cole & Bird, 1990)

Cohen-Cole and Bird developed a consultation model that has been adopted by The American Academy of Physicians for teaching the Medical Interview. Each of the below functions is served by a set of skills as listed in the table below.

1. Gathering data to understand the patient's problems.
2. Developing rapport and responding to patient's emotions.
3. Patient education and motivation.

Function	Skills
Gathering data Here is where the physician understands the patient's problems, by conducting an accurate interview. Understanding the patient's personal and social context would not only be useful for diagnosis but also to establish a suitable treatment plan.	• Open-ended questions • Open to closed one • Facilitation • Checking • Survey of problems • Negotiate priorities • Clarification and direction • Summarizing • Elicit patient's expectations • Elicit patient's ideas about aetiology • Elicit impact of illness on patient's quality of life
Developing rapport This is a crucial part in this model, where the physician carefully handles the relationship component of communication and the patient's emotion to promote a positive doctor-patient relationship using five types of empathic responses (expressed verbally or nonverbally).	• Reflection • Legitimating • Support • Partnership • Respect
Education and motivation In this last function, the physician stimulates and educates the patient to develop a clear and shared understanding about the nature of the problems, what must be done about them and a shared commitment to carry this out with better patient agreement and cooperation.	• Eliciting patient's existing views and knowledge • Education about illness • Negotiation and maintenance of a treatment plan • Motivation of non-adherent patients

Calgary-Cambridge Model (Kurtz & Silverman, 1996)

Suzanne Kurtz & Jonathan Silverman developed a model of the consultation, encapsulated within a practical teaching tool, the Calgary Cambridge Observation Guides. The guide is continuing to evolve and now includes structuring the consultation. The guides define the content of a communication skills curriculum by describing and structuring the skills that have been shown by research and theory to aid doctor-patient communication. The guides also make available a concise and accessible summary for facilitators and learners alike which can be used as an aide-memoire during teaching session.

Framework of the Calgary-Cambridge Guide (Kurtz & Silverman, 1996)

This model identifies five steps in a consultation. These steps are needed to provide structure to an interview and build a relationship with a patient. It identifies a number of specific skills (behaviours) a doctor should practice.

1. **Initiating the Session**
   - Establishing initial rapport
   - Identifying the real reason(s) for consultation
2. **Gathering Information**
   - Exploration of problems

- Understanding the patient's perspective
- Providing structure of the consultation

3. **Building the Relationship**
   - Developing rapport
   - Involving the patient
4. **Explanation and Planning**
   - Providing the correct amount and type of information
   - Aiding accurate recall and understanding
   - Achieving a shared understanding: incorporating the patient's perspective (illness framework)
   - Shared decision-making
5. **Closing the Session**
   - Summary
   - Contract
   - Safety-netting
   - Final check

Revised Content Guide to the Medical Interview (Calgary-Cambridge) (Kurtz et al., 2003)

In 2003, this model was revised to highlight both process and content components of the three-function model by combining the 'old' content with the 'new' content of the patient's perspective. It also includes a place for physical examination; eliciting both biomedical disease process and the patient's perspective, emphasising them as essential components of medical history.

1. **Patient's problem list**
2. **Exploration of patient's problems**
   - Medical perspective - disease
     - Sequence of events
     - Symptom analysis
     - Relevant systems review
   - Patient's perspective - illness
     - Ideas and beliefs
     - Concerns
     - Expectations
     - Effects on life
     - Feelings
3. **Background information - context**
   - Past medical history
   - Drug and allergy history
   - Family history
   - Personal and social history
   - Review of systems
4. **Physical examination**
5. **Differential diagnosis - hypotheses (including both disease and illness issues)**
6. **Physician's plan of management**
   - Investigations
   - Treatment alternatives

7. Explanation and planning with patient

- What the patient has been told
- Plan of action negotiated

This model is patient-centred where doctor-patient relationship is essential through the entire consultation. It emphasizes the importance of negotiating management options, explanation and planning. It also highlights the importance of providing structure to a consultation, the importance of skilful initiation as well as closure of a consultation. The complete checklist contains 71 skills which are highly recommended for physicians to read as well as use accordingly within their interview.

Summary of Calgary-Cambridge Observation Guide

The summary is concise, clear, simple and practical for teaching, assessment and evaluation. The summary can also be used in several clinical contexts and at several educational levels.

TOPIC	COMMENTS	COMPETENCY
PREPARING FOR THE SESSION		
Housekeeping etc.		1 2 3 | 4 5 6 | 7 8 9
INITIATING THE SESSION		
Greets patient		1 2 3 | 4 5 6 | 7 8 9
Introduces self, role		1 2 3 | 4 5 6 | 7 8 9
Demonstrates respect		1 2 3 | 4 5 6 | 7 8 9
IDENTIFYING REASON (S) FOR THE CONSULTATION		
Identifies problems with appropriate opening question		1 2 3 | 4 5 6 | 7 8 9
Listens, no interruption		1 2 3 | 4 5 6 | 7 8 9
Confirms list and screens for other problems early		1 2 3 | 4 5 6 | 7 8 9
Negotiates agenda		1 2 3 | 4 5 6 | 7 8 9
GATHERING INFORMATION		
Encourages patient to tell story, in own words, clarifying reason for attending now		1 2 3 | 4 5 6 | 7 8 9
Uses open and closed question technique		1 2 3 | 4 5 6 | 7 8 9
Listens		1 2 3 | 4 5 6 | 7 8 9
Facilitates – verbal and non-verbal responses, use of silence, repetition etc.		1 2 3 | 4 5 6 | 7 8 9
Picks up verbal and non-verbal cues		1 2 3 | 4 5 6 | 7 8 9
Clarifies patient understanding		1 2 3 | 4 5 6 | 7 8 9

Periodically summarizes		1 2 3 | 4 5 6 | 7 8 9
Uses concise, easily understood, jargon free		1 2 3 | 4 5 6 | 7 8 9
Establishes dates and sequence of events		1 2 3 | 4 5 6 | 7 8 9
Ideas, concerns, expectations		1 2 3 | 4 5 6 | 7 8 9
Encourages patient to express feelings		1 2 3 | 4 5 6 | 7 8 9
PROVIDING STRUCTURE		
Summarizes to confirm understanding		1 2 3 | 4 5 6 | 7 8 9
Progresses from one section to another using sign posting, transitional statements		1 2 3 | 4 5 6 | 7 8 9
Structures interview in logical sequence		1 2 3 | 4 5 6 | 7 8 9
Attends to time keeping, and keeping interview on task		1 2 3 | 4 5 6 | 7 8 9
BUILDING RELATIONSHIP		
Uses appropriate non-verbal behaviour		1 2 3 | 4 5 6 | 7 8 9
Develop Rapport – Accepts beliefs, empathy, provide support, deals sensitively.		1 2 3 | 4 5 6 | 7 8 9
Involves the patient – shares thinking, explains rationale, explains process during physical exam		1 2 3 | 4 5 6 | 7 8 9
EXPLANATION AND PLANNING		
Provides correct amount and type of information		1 2 3 | 4 5 6 | 7 8 9
Aids accurate recall and understanding		1 2 3 | 4 5 6 | 7 8 9
Achieves a shared understanding – involving patient perspective		1 2 3 | 4 5 6 | 7 8 9
Shared decision making in planning		1 2 3 | 4 5 6 | 7 8 9
CLOSING THE SESSION		
Forward planning, safety netting		1 2 3 | 4 5 6 | 7 8 9
Ensuring appropriate point of closure – summarizing, final check		1 2 3 | 4 5 6 | 7 8 9

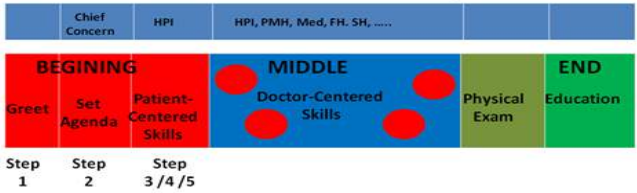
Patient-Centred Interviewing (Smith et al., 2001)

In 2000, Smith et al., established an evidence-based method for conducting a patient-centred interview with the following benefits:

1. Effective patient-centred interviewing improves health outcomes (Kaplan et al., 1989).

2. It improves patients' quality-of-life and satisfaction as well as increases physicians' professional and personal satisfaction (Suchman et al., 1988; Hall et al., 1988).
3. Decreases medical liability claims (Valent et al., 1988).

Comprehensive Clinical Method



Integrated Patient-Centred and Doctor-Centred Interviewing

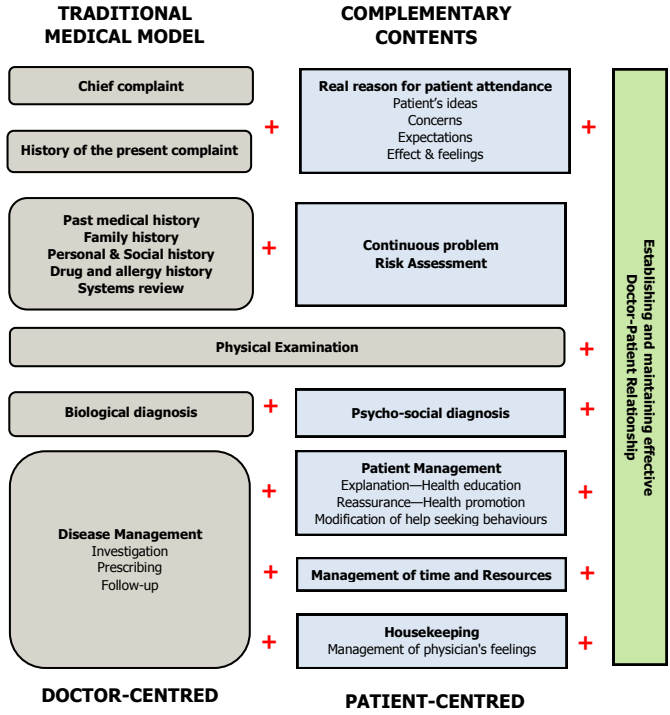
Basic Patient-Centred Interviewing Method	Basic Skills for Patient-Centred Interviewing
1. Setting the stage for the interview a. Welcome the patient b. Use the patient's name c. Self-introduction and specific role d. Ensure patient readiness and privacy e. Remove barriers to communication f. Ensure comfort and put patient at ease	Nonfocusing open-ended skills • Silence • Nonverbal encouragement (head nodding, leaning forward) • Neutral utterances, continuers ("um-hmm")
2. Chief complaint/Agenda-setting a. Indicate time available b. Indicate own needs; obtain a list of all the issues the patient wants to discuss c. Summarize agenda d. Negotiate agenda items to be covered in future visits if list is too long	Focusing open-ended skills • Reflection, echoing (e.g., patient says: "I'm worried;" physician echoes, "Worried?") • Open-ended requests ("Can you say more about that?") • Summary, paraphrasing
3. Opening the history of present illness (HPI) a. Open-ended beginning question/ statement b. Use open-ended skills to encourage story	Emotion-seeking skills • Direct ("How did that make you feel?") • Indirect: self-disclosure, impact on life, impact on others, and belief about problem
4. Continuing the HPI a. Develop physical symptom story b. Focus on impact of symptom on patient's life c. Determine emotion caused by this impact d. Address emotion i. Name ii. Understand iii. Respect iv. Support	Emotion-handling skills (NURS) • **N**aming, labelling (e.g., "You sound sad.") • **U**nderstanding, legitimation (e.g., "I can sure understand why . . .") • **R**especting, praising (e.g., "You have been through a lot.") • **S**upporting, partnership (e.g., "I am here to help you any way I can.")

5. Transition to clinician-centred interview a. Brief summary b. Check accuracy c. Indicate that style and content of interview will change d. Begin doctor-centred interview	

(Smith, 1996)

The New Comprehensive Clinical Consultation Model

This model integrates the traditional clinical method with effective communication skills, making good use of all the previous models, to help physicians create a model that best matches their needs. The aim of this model is to complement and not to destruct your traditional model of consultation.



The criteria of the new comprehensive consultation model

1. It is comprehensive and it integrates traditional clinical method with effective communication skills (patient-centred + doctor-centred)
2. It makes good use of all existing models. So the new comprehensive consultation model incorporates some important contents and skills not considered in the previous consultation models:

- Establishing and maintaining effective doctor-patient relationship is considered as an important task (Pandleton Model)
- Opportunistic health promotion. It should be every physician's business in all specialties (Stott & Davis Model)
- Managing continuous problem (Stott & Davis Model)
- Modification of help-seeking behaviour (Stott & Davis Model)
- Management of time and resources (Pandleton Model)
- Management of physician's feeling (housekeeping) (Neighbour's Model)

3. It adds important contents and skills not covered enough in the previous consultation models:
    - Making use of physical examination as part of doctor-patient relationship.
    - Preparation before seeing the patient (preparing yourself, place, patient's data)
    - Consider reassurance as an essential part of patient management is as important as prescribing medication and ordering investigation(s) (Balint, 1957).
4. It complements and it does not destruct or neglect the traditional biological model of most practicing physicians
5. As this model is built on what the learners already know, this will make the process of training more enjoyable and the behaviour change more attainable
6. It is simple and practical

This model is a summary of my Arabic book entitled:

كتاب الأسس العلمية للاستشارة الطبية

The New Comprehensive Consultation Model

Integration of communication skills with medical records

1. Chief complaint
2. History of the present complaint
3. Patient's ideas, concerns, expectations and feelings
4. Risk assessment and continuous problems
5. Past medical history
6. Family history
7. Social history
8. Systems review
9. Drug and allergy
10. Physical examination
11. Bio-psycho-social diagnosis
12. Disease and patient management

Tasks done but not written in medical records

1. Doctor-patient relationship
2. Management of time and resources
3. Management of doctor feelings (Housekeeping)

SELF-ASSESSMENT EXERCISES

Exercise 1

Q1. What are the missing skills in the traditional medical model?

_____

_____

_____

Q2. Why is it that 50% of the patients do not take their medicine?

_____

Q3. Why is it that 40% of the patients express their lack of satisfaction?

_____

Q4. How can you reassure your patients more effectively?

_____

Q54. Does the patient's complaint always have a biological explanation?

_____

Q6. If you are in doubt about diagnosis, what is the role of the patient?

_____

Q7. How can you manage if you have only 5-10 minutes for each patient?

_____

Q8. How can an unsatisfied physician satisfy his/her patients?

_____

Exercise 2

Read the following case scenarios, and discuss how you can apply the expanded model of consultation for each patient?

Case scenario 1

1. A 65-year-old retired military officer rarely visits the practice, he came today with back pain, headache and generalized weakness.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1._____

2._____

3. _____

4. _____

Case scenario 2

2. Sameera is a 14-month-old girl, her mother is very anxious because Sameera cannot walk independently till now. She demands that something be done about this. Sameera is the youngest of five children. Her father is unemployed.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1._____

2._____

3. _____

4. _____

Case scenario 3

3. Mrs. Hala is a 28-year-old lady, recently married, presents with vaginal discharge.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1._____

2._____

3. _____

4. _____

Exercise 3

The Comprehensive Consultation Model: Self-evaluation form

Patient Data:_____ Age:_____ Gender:_____

Reason for attendance:_____

Tasks	0	1	2
Doctor-Patient Relationship 1. Establish the relationship 2. Facilitation 3. Building rapport 4. Empathy 5. Making use of physical examination			

6. Partnership 7. Closing & maintaining the relationship 8. Preparation			
Comprehensive Bio-psycho-social Diagnosis 9. Gathering information about disease & illness 10. Broad thinking and exclusion of important differential diagnosis 11. Exclusion of possible serious complications 12. Identification of at risk factors & continuous problems			
Comprehensive Management *Patient Management:* 13. Explanation and Health Education 14. Reassurance: (remember: you are the most effective drug) 15. Health Promotion 16. Modification of help-seeking behaviour (denial, displacement) *Disease Management* 17. Intervention by investigations or treatment 18. Management of time & management of resources 19. Management of doctor's feelings (house-keeping)			

0= not done 1= done but not good enough 2= perfectly done

Write your feelings about your performance:

_____

_____

Important areas of strength and areas that need improvement:

_____

_____

Your specific learning needs and your action plan:

_____

_____

Exercise 4

Match the left list (Consultation Models) with the appropriate part of the right list (Characteristics):

Consultation Models	
A.	Traditional Medical Model
B.	Disease-Illness Model
C.	Calgary-Cambridge Guide
D.	Inner Consultation
E.	Stott & Davis
F.	Pendleton
G.	Balint

Characteristics	
1.	Doctor as a drug
2.	Doctor as an educator
3.	Patient as a partner
4.	Doctor has feelings
5.	Patient as a case
6.	Consultation has two sets of content‖
7.	Consultation has structure

FURTHER READING

1. Putting Communication Skills to Work
2. The Medical Interview - Evidence-Based Interviewing Method - A practical guide to teaching and assessing the ACGME Core Competency
3. مناهج الاستشارة الطبية و نهج الطبيب الحاذق (من كتاب الأسس العلمية للاستشارة الطبية)

REINFORCEMENT & SELF-ASSESSMENT

Practicing consultation skills with simulated patients leads to the acquisition of skills. However, physicians do not transfer these learned skills to clinical practice as comprehensively as they should.

Current evidence suggests that a good physician who attends short workshops or courses to improve his/her skills and then has an opportunity to receive feedback about how he/she communicates in real consultations will learn most.

Tips for learning new skills (Pendleton 2003 with modifications)

- Divide the change planned into small manageable amounts, and make one change at a time.
- Start asking the patients their ideas and concerns about their symptoms and what they would like you to do for them.
- Be comfortable with one new skill before starting another.
- When that feels comfortable you can encourage joint decision-making.
- Make a written plan for yourself at the beginning and the end of each clinic. Mentally review each consultation to see what was achieved.
    - Plan: This clinic, I will check each patient's understanding of the medicines prescribe.
    - Practice a new consultation skill when you do not have too much pressure. It would be wise to try out a new skill early morning when there are only few patients.
    - Continue to practice a skill until it no longer feels awkward. Change the words you use until they feel natural.
    - Do not be put off by the patient's initial reaction. It is probably new for them too, you need more explanation or you may need to try a variety of new phrases until you find the suitable words for you and your patients.
    - If you do not like "What do you think is wrong with you?" then try "Have you any idea what might be causing this?" or "What might have started this off?", "I was asking because some people might be worried about symptoms like this and I wondered if you were".

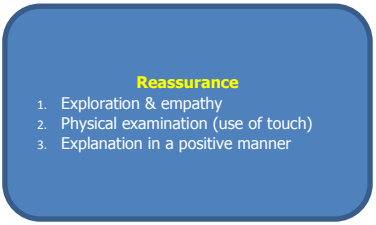
Tips to manage time effectively during consultation

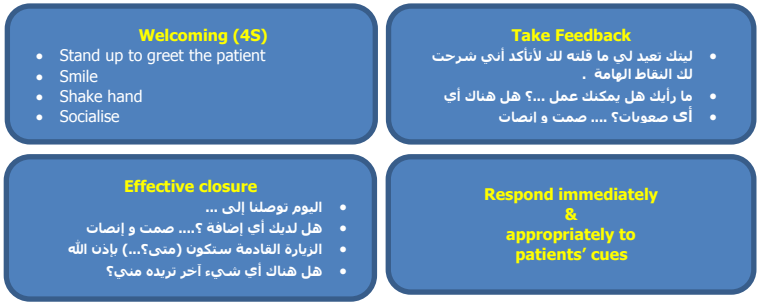
- **Start early or on-time:** Arriving to the clinic/hospital early will allow you time to get comfortable, have a drink, check your emails, start the computer and arrange for the first patient.
- **Improve your IT skills:** Struggling with your computer is definitely going to slow you down. Ensure that you familiarize yourself with the system along with any shortcuts that can be used. If you cannot touch type, learning to do so can also save a lot of time
- **Gather information in optimal time:** Using open-ended questions and empathic listening will allow you to gather information in a relatively shorter time compared to using close-ended and direct questions with interruption.

- **Organize the clinic:** Good organization saves time, e.g. instead of waiting for the patient to get ready for a physical examination, sending the patient to a separate examination room, will allow the doctor to start with a second patient.
- **Keep patients informed:** Many patients do not know the length of the appointment they have booked. Letting patients know when they book or through a poster in the reception/waiting areas will help them understand their expectations of the consultation.
- **Book appropriately:** If a patient has a number of things to go through, the patient should be informed that he/she has the option of booking a longer or double appointment in the next visit to spend time dealing with the problems effectively. Likewise when a patient, who you know always makes you run late, tries to book a follow-up appointment; encourage him/her to book double appointments so it does not affect your appointments.
- **Delegate:** Make use of the healthcare team whenever possible, e.g. the nurse in chronic diseases clinic can give health education to the patient and/or provide printed materials to reinforce important messages.
- **Ending the consultation:** When a patient continues to chat or prolong the consultation, despite the consultation clearly being over and the patient's needs have been met within the consultation; breaking rapport at this point is acceptable and necessary. Ways to do this include:
  - breaking eye contact
  - altering your body position away from the patient
  - speaking faster and louder than the patient
  - sitting up straighter
  - handing over a prescription or patient information leaflet
  - starting to stand up
  - In some cases, it may even be necessary to stand up and open the door for the patient.

Tools for training

Use reminder cards to help you master the new skills, place it on your desk in a position where you catch sight of it. In the card, include some examples of phrases which can help you practice the skills.





There are a variety of assessment strategies available - choose the one that is right for you. Whatever method you use, you may want to keep a workbook to monitor your progress. As you do your assessment, jot down skills that you feel you are doing well, some that you are improving on, and others that still need work.

HOW TO PERFORM SELF-ASSESSMENT

- After finishing your consultation, take a few minutes to reflect on your performance and make some mental or written notes about your own strengths and weaknesses (Gibbs, 1989).
- Try doing the self-reflection exercise as close as possible to the time of the consultation; otherwise, you are likely to forget the 'fine points' of the interaction.
- Use the evaluation forms and the checklists of this book to make the learning process more systematic.
- Try to concentrate on the new skills, for example, exploring ideas, concerns and expectations or encouraging doctor-patient partnership.

Audio taping and/or videotaping

It must be noted, however, that our perceptions of our own behaviour through reflection are not always accurate. It is often more useful to observe or listen to a recording of your interaction.

- Get the patient's permission before going ahead.
- Audio taping is cheap, more acceptable and easy; the only drawback being that it does not permit you to analyse your body language.
- Videotaping allows you to capture your expressions and other non-verbal behaviour; these days with new technology, it has become more available and handy. However, videotaping can be more threatening to patients.
- Use evaluation checklist to evaluate your recorded performance.

Patient feedback

- Patient feedback can be obtained through a questionnaire, issued after the interview session.
- In order to get feedback that is as honest as possible, take appropriate steps to ensure that the patient is offered the opportunity to respond anonymously.

- Example of patient feedback form:

4	3	2	1	تاريخ التقويم : .....
جيد جداً	جيد	مقبول	سيء	المؤشرات المختارة للتقويم
				1. هل حياك الطبيب و هو ينظر إليك باحترام و ترحاب
				2. هل شعرت أن الطبيب يقاطعك و لا يجعلك تكمل حديثك
				3. ما مدى رضاك عن درجة إنصات الطبيب لحديثك إليه
				4. هل استطعت أن تقول كل ما أردت أن تبوح به للطبيب
				5. ما درجة رضاك عن استشارتك لهذا الطبيب بشكل عام
			%	المجموع من 20× 5 = %

- Learners can use this form periodically to evaluate their progress. They can also change the questions according to the specific skills they want to evaluate.

Peer review

- You may ask a colleague to be present during your consultations (with the patient's permission, of course) to evaluate your performance or you may ask a fellow physician to review your session video or audio recordings.
- Set some ground rules for the peer review - for example, that discussions of weaknesses include a strong focus on suggestions for alternative approaches.

SELF-ASSESSMENT EXERCISE

Exercise 1

Look in the mirror and answer the following:

1. What are the 3 things you do very well in your consultation?

- .....
- .....
- .....

2. List the most important three areas in your consultation that need some modification.

- .....
- .....
- .....

3. What is your action plan?

- .....
- .....

- .....
- .....
- .....
- .....
- .....
- .....

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ANSWER KEYS

ILLNESS BEHAVIOUR

Exercise 1

Read the following patient scenarios and speculate the possible perspective of the patient's illness.

Case scenario 1

1. Mrs Salma is a 28-year-old divorcee, living with her 5 children, working as a teacher. Over the last 12 months, Salma has had intermittent episodes of soreness and stiffness in her knees.

➢ Possible ideas

- *She may think it could be rheumatoid arthritis*
- *It could be osteoarthritis*
- *It could be (bad eye) or (black magic)*
- *It could be infection or exhaustion*

➢ Possible concern

- *Her main concern could be her children, or her work*
- *She might be worried of losing the custody of her children or losing her work*
- *She might be worried of losing her chance of having another husband*
- *Her main concern could be her image as a distinguished teacher*

➢ Possible expectation

- *She may expect effective medications*
- *She may just want reassurance and explanation*
- *She may expect referral for investigations or possible surgery*
- *She may expect medical report or sick leave*

➢ Possible effect of the problem

- *The problem may affect her performance at work or at home*
- *It might affect her social activity*
- *It might affect her self-confidence*
- *It might disturb her sleep and affect her general well-being*
- *It might affect her future plans*

Case scenario 2

2. Mr. Naser is a 42-year-old teacher. He has chest pain

➢ Possible ideas

- *He may think it is from his heart*
- *He may think it could be a result of heavy meal*
- *He may think it could be (bad eye) or (black magic)*
- *He may think it could be trauma*

➢ Possible concern

- *His main concern could be his work*
- *His main concern could be his image as a distinguished teacher*
- *He might be worried his fitness*
- *He might be worried about his family, what will happen to them if he died*

➢ Possible expectation

- *His main expectation could be just explanation and reassurance*
- *He may expect ECG or X-Ray or cardiac catheterization*
- *He may expect referral for more reassurance*
- *He may expect medical report or just a sick leave*

➢ Possible effect of the problem

- *This problem may affect him physically and prevent him from doing his daily work or daily exercise*
- *It may affect him socially and make him isolated*
- *It may affect him psychologically and make him anxious and depressed*

Exercise 2

Think of how you might phrase questions to ask patients directly about their

Ideas	*What do you think it could be?* *What is in your mind?* *Do you think of any particular cause for this problem?*
Concerns	*What concern you most about this problem?*
Expectations	*What is your expectation?* *Is there anything in particular you need from me?*
Feelings	*Tell me about your feelings about this problem?*
Effect	*How are you doing at work?* *How are you doing at home? Does this affect your family?* *How are you doing at school?*

Exercise 3

Speculate possible causes of illness denial.

1. *Illness is a situation of weakens and no body like to be in a weak situation*
2. *Stigma of being ill*
3. *Lack of trust*
4. *Shame of possible ugly diagnosis*
5. *Seeking medical help cost effort , time and money …*
6. *Afraid from medication side effect or any possible aggressive medical intervention*

COMMUNICATION

Exercise 1

List what are the effective doctor-patient communication skills and what makes doctor-patient communication ineffective.

Effective Doctor-Patient Communication	Ineffective Doctor-Patient Communication
Welcoming	*Lack of welcoming*
Smiling	*Very serious attitude*

Showing interest and respect	*Lack of respect*
Listening carefully	*Interruption*
Friendly attitude	*Unfriendly attitude*
Eye contact	*Lack of eye contact*
Talking nicely	*Aggressive manner*
Showing care and professionalism	*Lack of empathy and unprofessional attitude*

VERBAL COMMUNICATION

Exercise 1

Explanation and health education: Self-evaluation form

When you go to your clinic try to apply the skills of explanation and health education with every patient, and whenever you have time use this checklist to evaluate your performance. You can also use role-play to train and evaluate your performance using this checklist.

Patient Data:_____ Age:_____ Gender:_____

Reason for attendance:_____

Skills	0	1	2
1. Give introduction about the importance of the topic			
2. Explore patient knowledge and feelings			
3. Empathic listening			
4. Deliver message in a positive way (reassurance)			
• Make your message simple & clear			
• Make it appropriate to the patient's education level			
• Make it a convincing message (logical explanation)			
• Make it organized & limited			
5. Frequently take feedback			
6. Invite patients to ask questions			
7. Response to patient's cues			
8. Repeat if necessarily (T3)			
• T1: Tell him what you will tell him (Introduction)			
• T2: Tell it			
• T3: Tell him what you have told them (Summary)			
9. Use demonstration if appropriate			
10. Always give hope and support			

0 = not done; 1 = done but not good enough; 2 = perfectly done

1. Write your feelings about your performance:

- *Satisfied and content*
- *Dissatisfied or partially satisfied*
- *Anxious or under pressure*

NB: Whatever your feelings may be, you need to write down why you felt that way, as this will help you to monitor your progress.

2. Important areas of strength and areas that need improvement:

The items in the checklist that you performed perfectly are your areas of strength.

3. Your specific learning needs and your action plan:

The items in the checklist that you failed to do or performed but not good enough are your areas of weakness. You need to list them so that you can focus on them in your future self-evaluations.

NONVERBAL COMMUNICATION

Exercise 1

1. State the different aspects of nonverbal communications:

a. Body language & Facial expression
b. Appearance
c. Touch
d. Paralanguage
e. Body bubble
f. Environment

Exercise 2

1. Write down three words that best describe the way you want to be perceived by your patients:

Most doctors like to be perceived by their patients as:
a. A caring and nice person
b. Skilful and updated
c. Friendly but professional

2. Write down how you can use your communication skills to convey these positive messages about yourself?

a. To let the patient know that you are a caring and nice person stand up and welcome him/her to your clinic, smile, shake his/her hand, put him/her at ease and break the ice through small talk about his/her life.
b. To show that you are a skilful and updated doctor you need to listen carefully to the patient's complaints, explore his/her ideas, concerns and expectations, perform a proper physical examination and convey appropriate explanation with reassurance.
c. To show that you are a friendly but professional doctor, you need to speak using simple terminology that the patient understands (no jargon), continuously take feedback from the patient and show empathy.

NB: All these are a few examples of proper communication skills. Every physician has his/her own communication approach that works best for him/her. Your communication skills affect how your patients perceive you; as a good or a bad physician.

DOCTOR-PATIENT RELATIONSHIP

Exercise 1

Role-play: With two colleagues, take turns being: (1) the doctor giving **nonverbal facilitation** responses, (2) the patient pretending to have problems and (3) the observer giving feedback using a 5-point scale. The observer must rate every response given by the doctor. Stop the interaction

after 4 or 5 responses have been rated. All three can discuss the good responses and how a certain response could have been more effective.

	Nonverbal Facilitation	1	2	3	4	5
1	Eye contact					
2	Silence					
3	Paralanguage					
4	Facial expression					
5	Touch					
6	Posture & Gestures					

NB: This is a reflection exercise designed to help every physician discover his/her own personal communication strengths as well as barriers and to consequently deal with them appropriately. Therefore, results will vary from person to person; keep repeating this exercise until you master all the skills.

Exercise 2

Role-play: With two colleagues, take turns being: (1) the doctor giving **verbal & nonverbal facilitation** responses, (2) the patient pretending to have problems and (3) the observer giving feedback using a 5-point scale. The observer must rate every response given by the doctor. Stop the interaction after 4 or 5 responses have been rated. All three can discuss the good responses and a how certain response could have been more effective.

	Verbal & Nonverbal Facilitation	1	2	3	4	5
1	Questioning					
2	Probing					
3	Confrontation					
4	Paraphrasing					
5	Verbal mirroring					
6	Interpretation					
7	Reflecting					
8	Summarizing					
9	Eye contact					
10	Silence					
11	Paralanguage					
12	Facial expression					
13	Touch					
14	Posture & Gestures					

NB: This is a reflection exercise designed to help every physician discover his/her own personal communication strengths as well as barriers and to

consequently deal with them appropriately. Therefore, results will vary from person to person; keep repeating this exercise until you master all the skills.

Exercise 3

Skills	How
Show interest & respect	• *Standing up for the patient* • *Using Nice welcoming phrases* • *Keeping appropriate eye contact*
Recognize verbal and non-verbal cues	*Reflect your observations by telling the patient: "you look anxious…." or "you look sad….."*
Immediately respond to patient's cues	*Ask the patient to speak more about his/her feelings, e.g. "tell me what's making you feel this way?", with appropriate eye contact and enough silence to give the patient time to respond.*
Show support and care	• *Verbally, e.g. by telling the patient "you have the right to feel this way" or "I will do my best to help you"* • *Nonverbally, e.g. by appropriate use of touch.*
Balance between intimate & professional relationship	• *Try to direct the patient to talk about his/her feelings without going in the details of long stories.* • *If the patient needs to contact you by telephone, give him/her your office number but not your personal mobile*
Be flexible & respect patient autonomy	*If the patient demands a specific intervention and you fail to convince him/her not to have it, if it is not iatrogenic and not very costly , you need to agree with him/her for the sake of maintaining the relationship*
Demonstrate appropriate confidence	• *Through positive gestures and appropriate eye contact* • *Through appropriate paralanguage (tone and pronunciation)*
Control your judgmental attitude	*When any patient makes you feel uncomfortable, try to recognise your feelings and stop judging the patient. Act according to "here and now"*
Respect patient confidentiality	*During consultation and after consultation*
If patient attends with his/her family: watch family dynamic, and build rapport with the family	• *Appropriately welcome all the family members* • *Give the family members a chance to explore the patient's complain* • *Direct your explanation to the patient and his/her family*

(Lang & Tennessee, 2002)

Exercise 4

Discuss the skills needed by physicians to maintain effective doctor-patient relationship while conducting physical examination

Case 1

Examination of a child

- *Lay out the consulting room with toys and drawing materials*
- *Make the childe feel comfortable*

- *Put aside time at the beginning of the consultation to build rapport*
- *Find out where the child is most comfortable - on the parent's knee or on the floor playing with toys, particularly during the examination*
- *Pay attention to proximity between you and the child - many children like you to be at their level*

Case 2
Examination of an elderly patient
- *Elderly patients may require additional time to undress and transfer to the examining table; they should not be rushed.*
- *Help the patient to undress before examination and dress after examination*
- *Maintain eye contact as much as possible while examining the patient.*
- *The examining table should be adjusted to a height that patients can easily access; a footstool facilitates mounting.*
- *Frail patients must not be left alone on the table.*
- *Portions of the examination may be more comfortable if patients sit in a chair.*
- *If patients become fatigued, the physical examination may need to be stopped and continued at another visit.*

Case 3
Examination of a patient of different gender than the doctor
- *You need chaperon, a nurse and/or patient's guardian/relative*
- *Ask patient's permission*
- *Talking while examining will decrease tension and break the ice*
- *You need to be very professional if there is risk of misunderstanding*
- *Avoid emotional issues while examining the patient*
- *Expose the necessary body part and then cover it as soon as possible*

Case 4
Examination of an anxious patient
- *Physical examination is very important for reassurance*
- *Keep appropriate eye contact and relaxed facial expression while examining the patient*
- *Recognize patient's cues and react accordingly*
- *Explain to the patient what you are examining*
- *Keep saying positive comments whole examining the patient*

Case 5
Examination of a patient in pain
- *Ask for patient's permission*
- *Start with less painful examination*
- *Try to be very gentle*
- *Keep eye contact to modify your examination according to your patient's pain-threshold*
- *Apologise to the patient for the pain and discomfort you caused during your examination*

Exercise 5

From what we have discussed in the previous chapters, write 30 strategies, verbal statements or nonverbal cues, which you may use during a consultation that would positively affect your relationship with your patient.

1. Prepare yourself before seeing the patient, e.g. get rid of any negative feelings caused by a previous consultation that made you feel uncomfortable	*16 Summarise*
2. Prepare the clinic before seeing the patient	*17. Take feedback*
3. Prepare patient file before seeing the patient	*18. Physical examination is very important to show your professionalism and for effective reassurance*
4. Stand up and shake the patient's hand	*19. Use gentle and non-threatening physical examination*
5. Welcome the patient using nice phrases and call your patient by name	*20. Keep a relaxed facial expression while examining the patient*
6. Smile and introduce yourself	*21. Say positive comments while examining and immediately after finishing the physical examination*
7. Socialize with the patient to break the ice	*22. Explain the diagnosis in a positive way*
8. Start with open-ended question	*23. While explaining the diagnosis, recognise and immediately respond to the patient's cues*
9. Give enough silence for patients to share their concerns	*24. Ask the patient for his/her feedback*
10. Do not interrupt the patient	*25. Negotiate the management plan and respect patients point-of-view*
11. Facilitation, encourage the patient to speak more about his/her concern	*26. Explain clearly in simple language avoid using jargon*
12. Maintain appropriate eye contact	*27. Ensure patient's satisfaction, e.g. "Anything else you need from me?"*
13. Respect his/her thoughts and feelings	*28. Make yourself accessible e.g. "you can come back anytime if you need to see me"*
14. Give him/her enough chance to talk about his/her feelings	*29. Stand up to say "see you next appointment"*
15. Showing empathy	*30. Give positive last impression*

NB: Remember to add feelings to your words

Exercise 6

Role-play: With two colleagues, take turns being: (1) the doctor giving **empathic responses**, (2) the patient pretending to have a variety of problems and (3) the observer giving feedback to the empathizer using a 5-

point empathy scale. The observer must rate every response given by the doctor. Stop the interaction after 4 or 5 empathic responses have been rated. All three can discuss the good responses and how a certain response could have been more effective.

	Empathic Responses	1	2	3	4	5
N	Naming the emotion					
U	Understanding & acknowledgement of suffering					
R	Respect and no criticism					
S	Support & silence					
E	Exploring and facilitating					

NB: This is a reflection exercise designed to help every physician discover his/her own personal communication strengths as well as barriers and to consequently deal with them appropriately. Therefore, results will vary from person to person; keep repeating this exercise until you master all the skills.

Exercise 7

How to share decision-making with patients

Steps	How
1. Define the problem that requires shared decision	*For example, tell the patient: "Let's decide together whether antibiotic will be of benefit for your throat infection or not"*
2. Legitimize patient involvement and encourage his positive role	*The decision depends on your personal needs and preference*
3. Outline the options: Describe one or more treatment options and, if relevant, the consequences of no treatment	*The advantage of taking antibiotic: it will shorten your illness by 24 hours. The disadvantage is the side-effect of the antibiotics*
4. Explore patient's ideas and encourage questions	*What do you think? What do you prefer? Do you have any question?*
5. Negotiate mutually acceptable plan	*Ok if you prefer to take antibiotic , it is going to be (….) you need to take it (…) you may develop (…) as side-effect of this antibiotic*
6. Recognize patient's verbal and non-verbal cues & respond to his cues	*You look uncomfortable with this side-effect?! Did you change your mind?*
7. Frequently take feed back	*Do you like to say anything?*
8. Give patient enough time to make his decision	*If the patient cannot make his final decision quickly , give him time to think and replay, especially for big decision like surgery or life-long medication*

Exercise 8

Discuss the below rapport building skills and their barriers

Skills	Barriers
1. Establish the relationship	
2. Facilitation	
3. Building rapport	
4. Empathy	
5. Making use of physical examination	
6. Partnership	
7. Closing & maintaining the relationship	
8. Preparation	

Discuss possible strategies that would help you to overcome these barriers

_____

_____

_____

NB: This is a reflection exercise designed to help every physician discover his/her own personal communication strengths as well as barriers and to consequently deal with them appropriately. Therefore, answers will vary from person to person; keep repeating this exercise until you master all the skills.

Exercise 9

Concentrate entirely on the decision-making aspect of the below consultations:

Case scenario 1
1. Atrial fibrillation
Patient wants to know about the pros and cons of warfarin and aspirin for prevention of stroke.

Case scenario 2
2. Benign prostatic hypertrophy
Patient wants to know more about the typical options that face a man who is told that he has "prostatism," with no other risk factors.

Case scenario 3
3. Menopausal symptoms
Patient undecided about hormone replacement therapy and anxious about the risk of breast cancer.

The objectives from these 3 scenarios:

1. *To review all the different updated options of management.*
2. *To evaluate the advantages and disadvantages of each option.*
3. *To practice how to present these information to the patient in simple understandable language.*

4. *To use the skills of shared decision-making checklist to evaluate your communication skills.*

NB: The above 3 scenarios are examples of clinical issues which require shared decision making. To benefit from this exercise, you must start the workshop by discussing management options, then applying the information in role-play with a friend/colleague, followed by performance evaluation using the shared decision-making checklist detailed in Exercise 7.

BREAKING BAD NEWS

Exercise 1

Case scenario 1

Mrs. Badria aged 39 years, pregnant for the first time. At 30 weeks' gestation, you diagnosed IUFD.

Q1. Speculate how this patient may feel.

- *Badria may feel very depressed for losing her baby*
- *She may inter into the cycle of bereavement and feel some time numbness of emotion and sometime disbelieve, anger and argument then she go to depression till she accept this bad news*
- *She may feel anxious about her health and the consequences of IUFD on her future chance to have another baby*
- *She may feel insecure about her relationship with her husband*

Q2. Discuss possible strategies in dealing with this patient.

Go through the steps of breaking bad news, the 6-step protocol – SPIKES

Q3. Suggest some specific verbal and nonverbal skills.

Examples of verbal skills:

- *"I imagine this is difficult news..."*
- *"You appear to be angry. Can you tell me what you are feeling?"*
- *"Tell me more about how you feel about what I just said."*
- *"What worries you most?" "What does this news mean to you?"*
- *"I wish the news was different."*
- *"I'll try to help you."*
- *Remind her that her responses are normal*
- *Remind her about religious principles e.g. the benefit of being patient*
  (وبشر الصابرين_المؤمن مُبتلى_عسى ان تكرهو شيئاً وهو خير لكم)

Examples of nonverbal skills:

- *Mirroring patient's gesture, facial expression*
- *Speak slowly in low tone*
- *Use touch whenever appropriate*
- *Give the patient her space to express her negative feelings by using silence and by avoiding eye contact at some stage of the consultation.*

Case scenario 2
Mr. Badr aged 39 years; investigations confirmed that he has AIDS

Q1. Speculate possible problems this consultation may raise
- *Badr may feel very depressed*
- *He may enter into the cycle of bereavement for losing his future and may become emotionally numb. He may also refuse to accept his diagnosis (denial), he might become angry and argumentative, and finally go into depression until he accepts the bad news*
- *He may feel ashamed due to the stigma of this diagnosis*
- *He may feel insecure about his relationship with his wife and children*

Q2. Discuss possible strategies in dealing with this patient
Go through the steps of breaking bad news, the 6-step protocol - SPIKES

Q3. Suggest some specific verbal and nonverbal skills
See Question 3, Exercise 1, Case Scenario 1

Case scenario 3
Mohammed is an 8-year-old lovely boy, he needs heart transplantation

Q1. Speculate possible problems in communicating with his parents
- *Here the doctor is dealing with 3 patients (the parents and the child)*
- *Parents might be very anxious and emotional*
- *The doctor may feel very sad for them and became emotional too*

Q2. Discuss possible strategies in dealing these problems
- *Direct the explanation to the parents and the child equally*
- *Speak with simple and clear language suitable for the child*
- *The doctor needs to balance between showing his/her empathy and being very objective while being scientific in his/her explanation of the situation and the prognosis of surgery*
- *The seating of the clinic should be children friendly to help the child to relax*

Q3. Suggest some specific verbal and nonverbal skills
Use reassurance
1. *Effective doctor-patient relationship*
    a. ***Credibility and trust:*** *e.g. telling the patient that you are an expert in this type of surgery and sharing your high success rate is definitely reassuring*
    b. ***Caring support:*** *e.g. attempt to help the patient and his family to overcome the administration obstacles as much as possible*
    c. ***Accessibility:*** *Patients with such life-threatening conditions need free access to their physician. Caring physicians usually have special mobile numbers that their critical patients can use to reach him/her at any time.*
2. *Exploration and good listening tips*
    a. ***Fears:*** *Encourage the patient and his family to explore their fears*

   b. ***Hidden agenda**: Try to be sensitive to any verbal or nonverbal cues in order to ask for any possible hidden agenda*
3. *Physical examination*
   a. *Because this patient was already diagnosed, physical examination would not be needed here.*
4. *Explanation and giving reassuring information.*
   a. *Avoid jargon, when naming the diagnosis*
   b. *Explain that it is not uncommon*
   c. *Answer the patient's questions and uncertainties.*
   d. *Discuss prognosis in a positive objective approach.*
   e. *Discuss the available treatment options.*
   f. *Empower the patient through positive thinking and faith.*
5. *Offer appropriate management option (care if you cannot cure).*
   a. *Support psychotherapy or counselling if needed and use referral when appropriate.*

Case scenario 4

Mrs. Badria, a 32-year-old lady with frequent somatic symptoms attends with a history of headache for the past 5 years. It appears to be tension headaches. She asks for a CT scan.

1. Discuss the patient's feelings

a. Headache can be a devastating symptom.
b. She may feel anxious about a serious diagnosis e.g. cancer, meningitis, epilepsy…
c. She may feel very anxious about possible complications, e.g. paralysis, blindness, death …
d. She may feel depressed and rejected by her family or friends or at work as a result of being ill most of the time

2. How would you proceed?

Use reassurance

1. *Effective doctor-patient relationship*
   a. ***Credibility and trust:** e.g. through a warm welcome and professional appearance*
   b. ***Caring support:** e.g. by respecting her suffering without any judgmental attitude towards her demand for CT scanning*
   c. ***Accessibility:** e.g. an easy appointment system and the option of using telephone consultation in an emergency situation will definitely reassure the patient*
2. *Exploration and good listening tips*
   a. ***Fears:** encourage the patient to explore all her feelings about this headache*
   b. ***Hidden agenda:** be alert to any possible hidden agenda, e.g. marital conflict or financial problem …*
3. *Physical examination*
   a. *There is no effective reassurance without physical examination: A doctor needs to do an appropriate physical examination to rule out all*

the patient's fear and ideas about a possible serious diagnosis or serious complications. After each part of examination, keep saying reassuring comments, e.g. "your neurological system is fine, your fundoscopy examination is very reassuring…"

   b. Remember the magical effect of touch: e.g. while touching the patient's head, the physician can say this is what we call 'tension headache', it is benign and common

4. Explanation and giving reassuring information.

   a. Avoid jargon, when naming the diagnosis, you can tell the patient "you have tension headache, which means because you are a sensitive stressor you feel this pain"
   b. Explain how common it is, e.g. "tension headache is very common these days as most people have lots of pressure at work and at home."
   c. Answer patient's questions and uncertainties.
   d. Discuss prognosis in a positive objective approach.
   e. Discuss the available treatment options.
   f. Empowering patients through positive thinking

5. Offer appropriate management option

Case scenario 5

Mrs. Salma is a 40-year old lady. She has a large uterine fibroid, attending today to discuss with you the hysterectomy operation.

Q1. Discuss the patient's feelings

a. She may feel very anxious about possible serious diagnosis. e.g. cancer
b. She may feel very anxious about the surgery and possible complications
c. She may feel very anxious about anaesthesia and possible complications
d. She may feel depressed for losing her uterus and her ability to be a mother again
e. She may think hysterectomy will affect her sexual relationship with her husband.

Q2. How would you proceed?

Use reassurance

1. Effective doctor-patient relationship

   *a. **Credibility and trust:** it is very reassuring to know that the attending surgeon is expert in this operation*
   *b. **Caring support:** warm welcoming , appropriate use of touch, and offering all possible help*
   *c. **Accessibility:** by giving follow up appointment after surgery, and if the patient still wary and need more information she may call you through the clinic telephone*

2. Exploration and good listening tips

   *a. **Fears:** you need to encourage her to explore all her idea , concerns and feelings . listen with empathy, without interruption and without judgment*
   *b. **Hidden agenda:** Doctor need to be alert to any verbal or nonverbal*

cues and try to encourage her to explore her hidden agenda, e.g. fear of sexual dysfunction

3. *Explanation and giving reassuring information.*
   a. *Avoid jargon, when explaining the surgery details*
   b. *Explain how common this surgery is.*
   c. *Answering patient's questions and uncertainty.*
   d. *Discuss prognosis in a positive objective approach.*
   e. *Empowering patients through positive thinking and faith.*

Exercise 2

Write 30 strategies that may help physicians to increase their **credibility** and be more effective in reassurance:

Verbal communication skills

1. *Say warm welcoming phrases to show your care and interest*
2. *Speak clearly*
3. *Speak with reasonable tone*
4. *Use simple understandable language*
5. *Use professional language*
6. *Use open ended question to make patient feel free to explore all his ideas, concerns and feeling*
7. *Repeat important massages to insure compliance*
8. *Take feedback frequently*

Nonverbal communication skills

9. *Keep eye contact with the patient*
10. *Use silence to encourage patient to talk*
11. *Use touch when appropriate*
12. *Work in reasonably organized clinic*
13. *Dress reasonably (not very casual, not very formal)*
14. *Mirror his patient facial expression*

Clinical competence

15. *Take appropriate history*
16. *Perform appropriate physical examination*
17. *Discuss the diagnosis*
18. *Share the uncertainty with the patient with confidence*
19. *Ask for reasonable investigation*
20. *Prescribe appropriate medication*
21. *Explain the diagnosis and management options clearly*

Professionalism

22. *Respect patient appointment and see the patient on time*
23. *Treat patient with respect e.g. stand up for welcoming*
24. *Respect patient autonomy (the right to decide for himself)*
25. *Respect patient confidentiality*
26. *Use step care approach in investigation and in management to reduce harm*

Dynamism

27. Use time during consultation appropriately
28. Move fast if needed
29. Speak with good energy in his paralanguage
30. Appreciate patient suffering and offer the most effective management option

CONSULTATION MODELS

Exercise 1

NB: With effective doctor-patient communication all the following barriers could be overcome easily.

Q1. What are the missing skills in the traditional medical model?

- *No exploration of patient ideas, concerns, expectation, effect of the problem and patient's feelings*
- *The psycho-social component of the patient's problem*
- *No illness management (Explanation, reassurance, health education and health promotion)*
- *No management of doctor feelings*

Q2. Why is it that 50% of the patients do not take their medicine?

There are many reasons for example:

- *Lack of trust*
- *Lack of appropriate explanation*
- *Lack of recognition of patient's point-of-view regarding medication, e.g. patient may have false belief about side-effect of the medication, or the patient may cannot afford buying expensive medications.*

Q3. Why is it that 40% of the patients express their lack of satisfaction?

Many reasons for example:

- *Unfriendly doctor attitude*
- *Failure to explore patient's idea, concerns, feeling and expectations*
- *Lack of empathy*
- *No explanation or inappropriate explanation*
- *Paternalism in doctor-patient relationship*

Q4. How can you reassure your patients more effectively?

- *First you need to listen carefully to patients' ideas, concerns, feelings and expectations*
- *Respect patients' ideas and deal with it appropriately*
- *No reassurance without appropriate physical examination*
- *Explain diagnosis to the patient in a positive way*
- *Ensure your accessibility and show your care*

Q5. Does the patient's complaint always have a biological explanation?

- *The answer is no*
- *Sometimes the problem is psycho-social only*
- *Psycho-social diagnosis need effective doctor-patient communication*

Q6. If you are in doubt about diagnosis, what is the role of the patient?
The patient is a partner and should be involved in every step of the consultation, starting from shared understanding of the problem and ending with shared decision-making about the problem

Q7. How can you manage if you have only 5-10 minutes for each patient?
Effective communication and continuity of care can make short consultation period very effective. Below are a few examples of some strategies that can be used:

- *Use open-ended questions to get more relevant information in a relatively short time*
- *A relationship of trust and respect between doctor and patient make patients more open and to the point*
- *Exploring the psychosocial component of a patient's problem will lead to correct diagnosis and reduce unnecessar future consultation.*

Q8. How can an unsatisfied physician satisfy his/her patients?
Physicians need to develop strategies to improve their personal satisfaction. They need to develop skills that will help them deal with negative emotions caused during consultations, immediately after consultations and continuously in the long run, (Neighbour, 2005). This technique is called 'housekeeping' and it is considered as the fifth task of any consultation, i.e. after every patient interview, a doctor needs to check him/herself for any negative emotion(s) and deal with it immediately to be able to serve the next patient efficiently.

Exercise 2
Read the following case scenarios, and discuss how you can apply the expanded model of consultation for each patient?

Case scenario 1
1. A 65-year-old retired military officer rarely visits the practice, he came today with back pain, headache and generalized weakness.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1. *The presenting problems are back pain, headache and generalized weakness.*
2. *The continuous problem is retirement and the health consequences of retirement*
3. *Help seeking behaviour that requires modification is his infrequent visit practice, he needs to know the importance of periodic health checkup; especially for his age*
4. *Appropriate screening and health promotion at this age according to the policy in your practice*

Case scenario 2

2. Sameera is a 14-month-old girl, her mother is very anxious because Sameera cannot walk independently till now. She demands that something be done about this. Sameera is the youngest of five children. Her father is unemployed.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1. *The presenting problem is Samara cannot walk independently.*
2. *The continuous problem is poor family, unemployed father, big family.*
3. *Help seeking behaviour that needs modification could be the mother is using the child as presenting complain while the real reason is psych-social stresses*
4. *Appropriate screening and health promotion at this age according to the policy in your practice*

Case scenario 3

3. Mrs. Hala is a 28-year-old lady, recently married, presents with vaginal discharge.

1. What are the presenting problems?	2. What are the continuous problems?
3. Is there any help seeking behaviour requiring modification?	4. What is the appropriate screening and health promotion?

1. *The presenting problem is vaginal discharge.*
2. *The continuous problem is recently married, she may need counselling and support.*
3. *There is no help seeking behaviour in this consultation that needs modification.*
4. *Appropriate screening and health promotion at this age according to the policy in your practice*

Exercise 3

The Comprehensive Consultation Model: Self-evaluation form

Patient Data:_____ Age:_____ Gender:_____

Reason for attendance:_____

Tasks	0	1	2
Doctor-Patient Relationship 1. Establish the relationship 2. Facilitation 3. Building rapport 4. Empathy 5. Making use of physical examination			

6. Partnership 7. Closing & maintaining the relationship 8. Preparation			
Comprehensive Bio-psycho-social Diagnosis 9. Gathering information about disease & illness 10. Broad thinking and exclusion of important differential diagnosis 11. Exclusion of possible serious complications 12. Identification of at risk factors & continuous problems			
Comprehensive Management *Patient Management:* 13. Explanation and Health Education 14. Reassurance: (remember: you are the most effective drug) 15. Health Promotion 16. Modification of help-seeking behaviour (denial, displacement) *Disease Management* 17. Intervention by investigations or treatment 18. Management of time & management of resources 19. Management of doctor's feelings (house-keeping)			

0= not done 1= done but not good enough 2= perfectly done

NB: This is a reflection exercise designed to help every physician discover his/her own personal communication strengths as well as barriers and to consequently deal with them appropriately. Therefore, answers will vary from person to person; keep repeating this exercise until you master all the skills.

Write your feelings about your performance:

_____

_____

Important areas of strength and areas that need improvement:

_____

_____

Your specific learning needs and your action plan:

_____

_____

Exercise 4

Match the left list (Consultation Models) with the appropriate part of the right list (Characteristics):

Consultation Models	
A.	Traditional Medical Model
B.	Disease-Illness Model
C.	Calgary-Cambridge Guide
D.	Inner Consultation
E.	Stott & Davis
F.	Pendleton
G.	Balint

Characteristics	
1.	Doctor as a drug
2.	Doctor as an educator
3.	Patient as a partner
4.	Doctor has feelings
5.	Patient as a case
6.	Consultation has two sets of content‖
7.	Consultation has structure

Answer:

Traditional Medical Model *Match with 5*
Disease-Illness Model *Match with 6*
Calgary-Cambridge Guide *Match with 7*
The Inner Consultation *Match with 4*
Stott & Davis *Match with 2*
Pendleton *Match with 3*
Balint *Match with 1*

NB: The Comprehensive Consultation Model has all these characteristics

REINFORCEMENT & SELF-ASSESSMENT

These are reflection exercises *designed to help every physician discover his/her areas of strength and areas that need further practice and improvement. Therefore, answers will vary from person to person; keep repeating this exercise until you master all the skills.*

Exercise 1

1. What are the 3 things you do very well in your consultation?

- .....
- .....
- .....

2. List the most important three areas in your consultation that need some modification.

- .....
- .....
- .....

3. What is your action plan?

- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

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