Physician-Patient Communication

Rhoda R. Redulla, MSN, RN
Hospital of the University of Pennsylvania
Philadelphia, Penn.

In the clinical arena, a variety of situations requiring creative communication skills are encountered by physicians. No practicing physician is spared from navigating the difficult scenarios that arise with the disclosure of crucial and sensitive information to the patient.

**Challenging Scenarios**

The optimal manner of communicating unpleasant news to patients, while maximizing patient understanding and facilitating psychological adjustment, varies from patient to patient. There are several ways to achieve this goal. Using open-ended skills such as echoing and summarizing1 has been cited as one way to individualize communication and is especially helpful with distressed patients. Another method is the application of the “evidence-based patient-centered interviewing method” initially described by Smith.1 Additional requisites on the part of physicians are personal self-awareness, an ability to access the emotional context of the conversation, and remain “emotionally articulate” as discussed by Buckman and others.2

In the gastroenterologic setting, a variety of scenarios require careful and delicate methods of communication. Chronic hepatitis C patients who complete the 48-week standard-of-care therapeutic regimen may need to be informed of relapse or viral breakthrough. Patients with inflammatory bowel disease who have failed medical therapy will also require consultation, often regarding the need for surgery. The creation of an ostomy may relieve gastrointestinal symptoms and prevent disease progression, but it results in a change in the body that is highly visible to the individual and affects personal and private functions.3

Psychological conditions can also manifest as gastroenterologic symptoms that require careful patient counseling. These patients can be characterized as generally distressed high utilizers of medical services, who often have unrecognized psychiatric problems,4 ranging in severity and complexity from social anxiety disorder to borderline personality. Their complaints may manifest as fatigue, unexplained abdominal pain, or headaches. When conventional medical therapy has failed to address these patients’ complaints, there may be an indication that their symptoms arise from psychological issues and they need to be referred for psychiatric consultation. Symptoms of nausea and vomiting with no known etiology or response to therapy may also warrant psychological tests and evaluation or psychiatric consultation. Psychogenic vomiting and eating disorders such as anorexia nervosa or bulimia are recognized causes of these symptoms.5 In a study of difficult doctor-patient relationships, difficult patients were much more likely to have a mental disorder, particularly multisomatoform disorder, panic disorder, dysthymia, generalized anxiety, or major depression. Physicians treating these patients were unenthusiastic about providing care, saw difficult patients as frustrating and time-consuming, felt manipulated by them, and did not look forward to return visits.6 When a patient is referred for psychological evaluation, a variety of outcomes may be observed. The optimal reaction would be one of ready acceptance by the patient and the immediate scheduling of a psychiatric consult appointment. Although there would likely be no immediate improvement in patient symptoms, the patient would at least be aware and accepting of the possibility of psychological contributing factors. Alternately, the patient may delay or even decline the referral, or view the referral as a rejection or refutation of their physical illness by their medical care provider. Psychoeducation can provide a frame of reference to help patients understand that physical symptoms may be exacerbated by anxiety or other emotional problems.7 Systematic presentation of assessment and test results that fail to show a physiologic cause of symptoms may help the patient accept the referral.
Physician Perspective

Physician difficulties commonly develop due to fear of the patient’s perceived or predicted reaction. Physicians have a natural reluctance to cause distress due to bad news that may have a significant impact on the patient’s personal life, career, finances, and family. Physicians may also have anxiety regarding the wide range of manifestations of patient reaction. The patient may exhibit anger, denial, or fear when bad news is received, all of which the physician may feel ill-equipped to manage to their own or the patient’s satisfaction. Literature also cites physicians’ anticipation of being blamed for bad news and the possible attribution of undesirable outcomes to the failure of medical staff. The thought of being blamed by the patient can elicit a considerable amount of anticipatory stress for the physician. Doctors may postpone uncomfortable interviews for longer than is reasonable, frequently because of the emotional distress that they themselves feel.

Patient Perspective

For patients, specific concerns are relatively easily identified. The perceived impact of the news received can trigger anxiety or anger regarding poor prognosis, unpleasant or tedious treatment, social stigma attached to disease condition, and concerns regarding the availability of treatment resources.

Communication Process

In a study aimed at improving doctor-patient communication, the MAAS-global rating scale was developed to evaluate consultation skills of doctors. Specific communication skills for each phase of the consultation were outlined. Introduction, follow-up consultation, request for help, physical examination, diagnosis, management, evaluation of consultation, exploration, emotions, information giving, summarizations, structuring, and empathy are each evaluated as separate categories. Among these aspects, emotions, structuring, and empathy are the most important in effective communication.

Other literature has described how physicians can fail to convey empathy during patient encounters. In the present managed care environment with heightened pressure on clinical productivity, physicians may be particularly concerned about the length of office visit and the effect of addressing patients’ emotional issues. A lack of emphasis in physician training on acknowledging the patient’s feelings also contributes to failure of empathy conveyance. Most physicians were trained to elicit symptoms of disease using a “doctor-centered” interviewing method. Personal concerns are largely ignored and discouraged so that the interviewer can focus upon making a disease diagnosis.

Tools and Strategies

Physical and Social Setting

Difficult patient conversations should occur in a quiet and calm physical environment. A very practical and simple rule is to make sure that the physician, as well as the patient, is seated for the consultation. Sitting down sends important subliminal signals to the patient: the physician is there to listen, the physician is (to some extent) under the control of the patient, and, if eyes can be kept level with the patient’s, the physician is engaging in nonpatronizing communication. This also conveys to the patient that the conversation is not hurried.

Further, face-to-face contact between physician and patient should be encouraged as much as possible. Physicians should sit close to the patient with no physical barriers separating them. In addition, it is important to recognize that bad news is communicated in a variety of ways, including the body language one uses. Folded arms and closed hands or laced fingers might indicate a reticence to talk or to divulge personal information. Making eye contact also makes a huge difference in the communication process. The patient is much less likely to feel that their views are being ignored or that information is being concealed when eye contact is being regularly maintained.

Finally, efforts should be made to arrange support and personal companionship for the patient. A companion can offer emotional support and may often be able to retain more information than the patient, as they are slightly distanced from the distressing impact of the news. Family or a significant other ideally should be present, but whether or not the patient prefers to discuss their condition alone should be determined first. Physicians may introduce the topic with a comment such as, “I assume you’re happy to discuss your condition with your husband present.”

Message

The message to the patient should be simple and direct, avoiding unfamiliar medical terminology, which can add to the patient’s confusion and anxiety. Physicians should consider terms such as “precancerous” rather than “dysplasia” and “scar tissue in the liver” instead of “advanced fibrosis.”

Results of a grounded-theory study on the framing of oncologist-patient prognostic communication showed that when physicians discuss negative outcomes, they tend not to refer to the patient directly. General and indirect language was more commonly used as a means to buffer the patient from news of poor prognosis and allow them to more gradually and rationally deal with the physical, psychosocial, spiritual, and financial concerns that arise as part of the disease course.
Physicians should provide a precursor comment that sets the tone for the conversation (eg, “I’m afraid I have bad news”). The physician can also start by reviewing what the patient already knows. For example, a patient may have existing knowledge of extensive Barrett esophagus and undergo evaluation for dysplasia. Consultation and examination may confirm the presence of an adenocarcinoma instead. The physician could begin with the patient’s understanding of Barrett esophagus and move forward to explain recent findings.

An essential component of these conversations is the offering of hope to the patient, wherever appropriate. Complete and honest information should be conveyed, but any realistic possibility of a positive outcome should also be emphasized to the patient and any family present. In the above scenario, the physician should be prepared to discuss a treatment plan. Ideally, information on the other providers to whom the patient will be referred, including the oncologist or surgeon, should be readily available.

It is also important to convey bad news at a pace comfortable to the patient, allowing time for them to process the information received. Content of the conversation should be summarized at the end of the visit and, whenever possible, written information provided, which will allow the patient to develop a better understanding after any initial shock has abated. The inability of patients and families to process and later recall information conveyed in these situations has been empirically documented.11

Maintaining a balance between biomedical and psychosocial issues is also important. Recent study has shown that although patients frequently discuss psychosocial issues, physicians rarely react appropriately. A recent report in the palliative cancer care literature found that in communicating with patients, doctors devoted 64% of their conversation to biomedical issues and only 23% to psychosocial issues.15 Determining the patient’s major reasons for seeking care is of critical importance for a successful medical encounter. Increasingly, emphasis is laid on the importance of establishing the patient’s agenda and list of priorities.13 The vast majority of patients have no acutely threatening problem, are able to communicate, are not prohibitively anxious, and want to talk about their symptoms, interests, fears, and concerns. In these more common situations, the interviewer initially allows the patients to lead the conversation and discuss the symptoms or personal issues she or he prefers.16 The clinician must be prepared to function in a variety of roles in these instances, ranging from advocate to counselor, friend, disciplinarian, coach, and even cheerleader.6

**Conclusion**

Communication between providers and patients regarding bad news and negative outcomes creates a genuine cause for concern. Physicians should attempt to make this crucial process as patient-centered as possible. Adequate preparation of information and planning of the discussion can help in the effective communication of difficult information. The strategies discussed should be implemented selectively, based on the patient’s circumstance and setting.

**References**