

A Guide to Learning & Applying EFFECTIVE COMMUNICATION SKILLS to Optimize the Provider Patient Relationship

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The Concept of Patient Centered Care²

Patient centered care as originally defined by the Institute of Medicine almost 20 years ago means that care is respectful of, and responsive to patient preferences, needs and values, and that patient values guide clinical decisions. This term may be misunderstood by some who believe that a clinician might give up control to the patient. This is incorrect and several of us in the field have considered a change in the terminology to “relationship centered care” which clarifies the collaborative nature of the clinical interaction.

There are several components to establishing patient centered care: respect for the patient’s knowledge and perspective, providing physical comfort and emotional support, offering education and reassurance, being accessible and collaborative, and making decisions based on patient preferences. To accomplish these goals, the clinician uses effective communication strategies to understand the full nature of the patient’s symptoms, and their illness experience in addition to their needs, perceptions, concerns, and impact the illness is having on their life.

10 Tips to Maximize the Patient Provider Relationship

The following was presented as part of the ACG David Sun Award lecture by Douglas A. Drossman MD.¹

> **1. Listen actively.** Don’t jump in with questions unless you’ve made the effort to understand the patient’s perspective. “Don’t just do something, stand there.”

> **2. Understand the patient’s agenda.**

The issues patients seek to address are often not stated because they have not been given the opportunity, or have not been aware of them until the clinical visit. Common concerns relate to the impact of the illness on their life, the possibility of cancer, fear for future consequences and many more. Discussion of these issues improves patient satisfaction. Here are four important questions to ask on the first visit:

- a. What brought you here today?
- b. What do you think you have?
- c. What worries or concerns do you have?
- d. What do you feel I can do to help?



> **3. Empathize.** An empathic statement would be: “I can see how difficult it is been to manage with your pain.” Empathy incorporates four components:³

- a. Perspective taking: Seeing the world as the patient sees it.
- b. Being non-judgmental.
- c. Recognizing the emotions and understanding the patient’s feelings.
- d. Communicating that understanding to the patient.

> **4. Validate thoughts and feelings.** Validating the patient’s thoughts and feelings shows that you are acknowledging and legitimizing them. Though you may not necessarily agree, you are still accepting their perspective. A validating statement for a patient who feels stigmatized by others who say their problem is due to stress would be: “I can see you are upset when people say this is due to stress and you know it’s real.” This statement also opens the door to further dialog about the role of stress in illness.

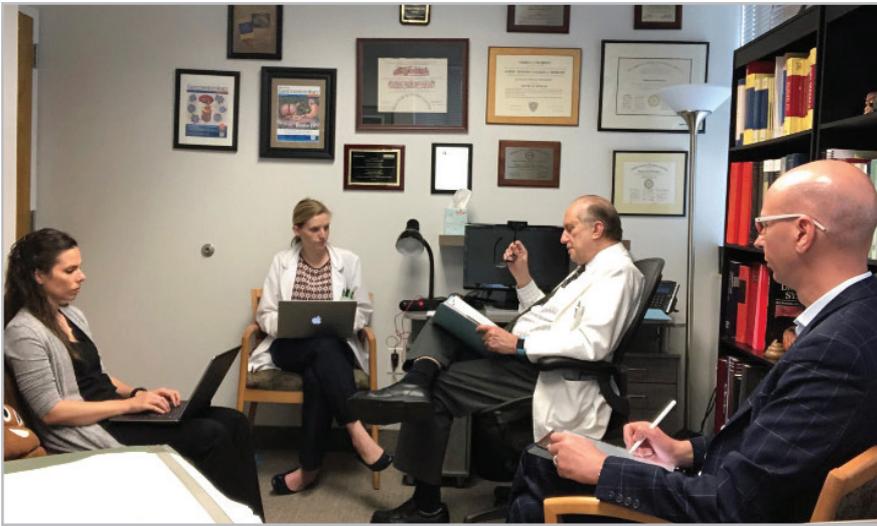
> **5. Set realistic goals.** Some patients with chronic illness may seek a rapid diagnosis, perhaps of a structural disease, and a cure. However, ~~but~~ the clinician may see the need to focus on ongoing management with realistic expectations for outcome. This difference in perspective needs to be reconciled. Here, you can say: “I can understand how much you want these symptoms to go away, but they are longstanding, and as such we need to reset our expectations. If we could seek to reduce your symptoms by 30 % over the next several months would that help?”

> **6. Educate.** Education is a four step iterative process:

- a. Elicit the patient’s understanding.
- b. Address misunderstandings.
- c. Provide information consistent with the patient’s understanding
- d. Check the patient’s understanding of what was discussed.

> **7. Reassure.** Reassurance requires you to:

- a. Identify the patient’s worries and concerns,
- b. Acknowledge and validating them,
- c. Respond to these specific concerns.
- d. Avoid false reassurances (e.g., “don’t worry about it”) that can sound dismissive, as if their feelings aren’t valid.



The Value of Non-Verbal Behavior and Body Language in Communication⁴⁻⁶

We can say that to effectively engage with patients “it is not what you do but how you do it that makes the difference.” Nonverbal communication is the underpinning that establishes a sense of connection. Gestures, proxemics and nonverbal signals are the most primitive and basic form of communication that preexists language, and they legitimize the credibility and veracity of what is said. Effective nonverbal communication has also been associated with greater patient satisfaction, adherence to treatment and a greater patient caseload due to patient satisfaction.⁷ Consider the two figures of a patient provider interaction. What can you learn about the provider patient relationship even without hearing the words?

> **8. Negotiate.** Patient centered care requires mutual agreement on diagnostic and treatment options. The doctor, after eliciting the patient’s personal experience, understanding and interests in various treatments, then provides choices (rather than directives) that are consistent with the patient’s beliefs. IOM guidelines require the patient to make the final decision.²

> **9. Help the patient take responsibility.** Patients with chronic illness do best when they take responsibility for their care and clinicians must encourage this. So rather than asking the patient: “How is your pain doing?” you might say: “How are you managing with your pain?”. The second question encourages the patient, rather than the clinician to take an active role in management. This also offsets clinicians from feeling pressured to take more responsibility than needed. With treatment it is wise to offer several treatment approaches with a discussion of their risks and benefits, so the patient can make the choice.

> **10. Be there.** This means providing support and a listening ear. Sometimes patients disclose personally meaningful and sensitive issues that have no simple solutions. They are not seeking a simple solution as much as to know they are being heard, understood, and supported.



The doctor:

- avoids eye contact while looking at the medical record
- is turned away from the patient
- waves his hand in a dismissive manner

The patient:

- looks down with slumped shoulders
- crosses arms and legs showing passivity and nonacceptance



The doctor:

- faces the patient making good eye contact
- the finger on the chin indicates receptive thinking and active engagement

The patient:

- perceives greater interest and acceptance by the doctor
- she is encouraged to say more
- now displays an open posture and active gesturing

Verbal and Non-Verbal Behaviors Affecting Communication¹

This table notes the behaviors that can facilitate or inhibit the medical interview.

BEHAVIOR	FACILITATES	INHIBITS
Nonverbal		
Clinical environment	Private, comfortable	Noisy, physical barriers
Eye contact	Frequent	Infrequent or constant
Listening	Active listening – questions relate to what patient says	Distracted or preoccupied (e.g. typing)
Body posture	Direct, open, relaxed	Body turned, arms folded,
Head nodding	Well timed	Infrequent, excessive
Body proximity	Close enough to touch	Too close or too distant
Facial expression	Shows interest and understanding	Preoccupation, boredom, disapproval
Voice	Gentle tone	Harsh, rushed
Touching	Helpful if well timed and used to communicate empathy	Insincere if inappropriate or not properly timed
Synchrony (arms, legs)	Concordant	Discordant
Verbal		
Question forms	Open ended to generate hypotheses	Rigid or stereotyped style
	Closed ended to test hypotheses	Multiple choice or leading questions (“You didn’t... did you?”)
	Use of patient’s words	Use of unfamiliar words or jargon
	Facilitates patient discussion by “echoing” or affirmative gestures	Interruptions, undue control of conversation
	Uses summarizing statements	Not done
Question/Interview style	Nonjudgmental	Judgmental
	Follows lead of patient’s prior comments (patient centered)	Follows own preset agenda or style
	Use of a narrative thread	Unorganized questioning
	Appropriate use of silence	Interruptions or too much silence
	Appropriate reassurance and encouragement	Premature or unwarranted reassurance or encouragement
	Communicates empathy	Not provided or not sincere
Recommendations	Elicits feedback and negotiates	No feedback, directly states views
Asks/provides medical information	As appropriate to the clinical issues	Too many bio medical questions and too detailed information
Asks/ provides psycho-social information	Elicits in a sensitive and nonthreatening manner	Ignores psychosocial data or asks intrusive or probing questions
Humor	When appropriate and facilitative	None or inappropriate humor

Key Definitions Relating to Communication

Patient Satisfaction. Patient satisfaction relates to the patient’s perception of the doctor’s humaneness, technical competence, interest in psychosocial factors and his/her provision of relevant medical information. However, too much focus on biomedical issues can have a negative.^{8,9}

Engagement. Engagement is the connection established where patient and provider work together in the care process. Factors improving engagement are often nonverbal: 4 good eye contact, affirmative nods and gestures, a partner like relationship, closer interpersonal distance and a gentle tone of voice.

Empathy. Empathy means understanding of the patient’s pain and distress, while maintaining an objective stance. An empathic statement would be: “I can see how much this has affected your life”. The components are: 1. Seeing the world as others see it (perspective taking), 2. Being non-judgmental, 3. Understanding another’s feelings (recognizing emotion), and 4) Communicating that.³

Validation. Validation relates to accepting the thoughts and feelings of the patient without judgment. A validating statement to a patient who is feeling shamed or stigmatized because others say their problem is due to stress would be: “I can see you are upset when people say this is due to stress and you know it’s real”. This statement can also open the door to further dialog about the role of stress in illness.

What Providers and Patients Should Know^{5,6}

Patient-centered care is a partnership where both provider and patient share responsibility. To do this it is important to be familiar with each other’s needs and expectations:

Doctor should know and be able to show	Patient should know
That you care about your patients and are not judgmental.	Their role in the care and their health status are worth fighting for, no matter what.
You respect your patients enough that they can share personal details that will assist you in their care.	They can demand to be treated with dignity and respect.
That you are receptive to their thoughts and feelings.	They have a right to share personal thoughts and feelings about their illness and care.
Patients need to understand the diagnosis and treatment plan in order to participate, and feel like they have a say in the process.	They have a right to ask questions and receive visual aids to understand the diagnosis and treatment.
That patients are not impressed with ego and prestige. They want you to be humane and to care about the impact of the illness on their life.	They have a right to be heard.
That it is okay to say “I don’t know” as long as you continue to work with them, or guide them to someone who will.	They have the right to engage with you, the provider, as a partner
That you will not abandon them in the care.	They have the right to refuse treatment or seek another opinion if their needs are not being met.

References

1. Drossman DA. 2012 David Sun Lecture: Helping your patient by helping yourself: How to improve the patient-physician relationship by optimizing communication skills. *American Journal of Gastroenterology*. 2013;108(5):521-528.
2. Medicine Io. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Vol 1. 1 ed: National Academy of Sciences; 2001.
3. Wiseman T. A concept analysis of empathy. *J Adv Nurs*. 1996;23(6):1162-1167.
4. Hall JA, Harrigan JA, Rosenthal R. Nonverbal behavior in clinician patient interaction. *Applied and preventive psychology*. 1995;4:21-37.
5. Drossman DA. From Pretending to Truly Being OK: A Journey From Illness to Health With Postinfection Irritable Bowel Syndrome: The Provider's Perspective. *Gastroenterology*. 2018;155(6):1664-1665.
6. Ruddy J. From Pretending to Truly Being OK: A Journey From Illness to Health With Postinfection Irritable Bowel Syndrome: The Patient's Perspective. *Gastroenterology*. 2018;155(6):1666-1669.
7. Dimatteo MR, Hays RD, Prince LM. Relationship of physicians' nonverbal communication skill to patient satisfaction, appointment noncompliance, and physician workload. *Health Psychol*. 1986;5(6):581-594.
8. Bertakis KD, Roter D, Putnam SM. The relationship of physician medical interview style to patient satisfaction. *Journal of Family Practice*. 1991;32(2):175-181.
9. Hall JA, Dornan MC. What patients like about their medical care and how often they are asked: A meta-analysis of the satisfaction literature. *Soc Sci Med*. 1988;27(9):935-939.

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