



Effective Communication : Core skills of Family Physicians to build up successful practice

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Objectives

1. Explore common pitfalls in communication skills in family practice
2. How would good communication skills help family doctors to avoid misdiagnosis

A lot of problems and errors in clinical practice would be due to problems in communication. Not only doctors' errors, a lot would be due to patients' errors.

Doctors might not fully understand from patients' perspectives or fails to explain to patients clearly the diagnosis and management.

Alternatively patients might not fully understand doctors' explanation. They might fail to express their problems and needs fully.

The breakdown in communication might not be intentionally but it would lead to failure in disease management, poor compliance to drugs and medical advice and adverse effects of treatment.

The problems of doctor-patient communication are more frequent amongst elderly due to decline in vision and hearing, cognitive function and comprehension ability. However errors are more likely to happen in elderly.

In family practice, the communication between doctor and patient bears an important rate in consultation process.

The unique feature of successful family doctor is that communication takes place between the family doctor and patient who have known each other for sometime and have shared previous experiences, and have other relationships in common e.g. with other family members.

Kostopoulou O, Delaney BC and Munro CW. Diagnostic difficulty and error in primary care – a systematic review. *Family Practice* 2008; 25: 400-413.

- Five features of potential diagnostic difficulties: atypical presentation, non-specific presentations, very low prevalence, co-morbidity and perceptual features.
- Many of the misdiagnosis is misattribution of the presenting symptoms to an obvious explanation or readily available aetiology especially in absence of typical features.
- An existing diagnostic label hampers doctors to restructure the diagnostic problem and searching for alternative explanations.
- GPs are more likely to diagnose difficult cases if they gather more clinical information. Hypotheses generation is the key for searching critical information.
- Difficult presentations and rare problems are likely to be misdiagnosed by ‘pattern recognition’.

Diagnostic Process in Family Medicine

- **Diagnostic fallacy that family physicians would make diagnoses by collection clinical information in routine fashion**
- **Family physicians started off the process in formulation of provisional diagnostic hypotheses**
- **They then test the hypotheses by selective collection of clinical information from patient's history, clinical examination and laboratory test.**

Diagnostic Process in Family Medicine

- **In the course of research, family physician will look for positive (confirming) and negative (refuting) evidence.**
- **This is hypothetico-deductive approach**
- **The process is cyclical and family physicians must prepare to revise and test the hypotheses further until it is refined to the point at which management decision is justified.**
- **Purely deductive approach can play relatively small role on some occasions**

Cues in Diagnostic Process

- **When a patient presents a problem, the family physician is faced with a large data set: what patient says, the family physician's own observations, previous knowledge of the patient, relatives, from other physicians or other health professionals**
- **The different types of information are not of equal value and family physician responds to certain types of information having special meaning.**
- **We call these 'cues' and it helps family physicians to understand the context of problem and/or understand the patient**

Cues in Diagnostic Process

- **A cue can be a symptom, sign, statement, or an aspect of patient's behaviour**
- **It may be something that is known about the patient such as age, sex, ethnicity, occupation, past history**
- **It may be a contextual cue such as teenage girl accompanied by mother, a symptom tolerated by patients for years before presenting**
- **It may be a subjective cues**
- **Cues can be certain or probabilistic**

What is communication?

Communication is the process whereby humans collectively create and regulate social reality. Processes are dynamic with no beginning or an end and constantly changing.

(Trenholm S, Jensen A. Interpersonal communication. Oxford University Press, 2004, New York.)

What does a person have to know or be able to do in order to communicate in a personally effective and socially appropriate manner?

To be competent communicators, they need to do few things well:

- Assign meaning to the world around them
- Set goals strategically
- Take on social roles appropriately
- Present a valued image of themselves to the world
- Generate intelligible messages

Competencies in communication

- **Message competency**- the ability to make the message choices that others can comprehend as well as to respond to the message choices of others
- **Verbal competency**- the ability to process and use linguistics devices to convey content in effective ways.
- **Non-verbal competency**- the ability to process and use nonverbal codes to convey content in effective way such as body movement, facial expression, use of time and space, physical appearance.
- **Relational competency**- the ability to process and create message that convey the type of relationship assumed or desired by the communicator at a given moment

Competencies in communication

- **Interpretive competency**- the ability to label, organize, and interpret the conditions surrounding an interaction
- **Role competency**- the ability to take on social roles and to know what is appropriate behaviours given these roles
- **Self competency**- the ability to choose and present a self desired image, i.e., knowing who they are and who they want to communicate to.
- **Goal competency**- the ability to set goals, anticipated probable consequences and choosing effective lien of action.

Patient's Perspective

In the foreign environment of the doctor's office, patients feel that they have little ability to assert their unique identity and sense of competence.

One of the main reasons with unfulfilled agenda relates to the difficulty many doctors have in addressing illness with the biopsychosocial complexity, in contrast to disease, which designates the biomedical abnormality alone.

Patient might want more than diagnosis and management plan but also reassurance and explanation.

Physician's Perspective

When the doctor really attends to the patient's story, not only patients feel that their voices have been heard, they are more likely to ask questions, receive information about what their symptoms mean, participate in decision making and leave them with the feeling that their issues have not been abandoned.

Doctors wish to see themselves helpful and caring, are often unaware of their stereotype and 'less' desirable gestures.

In family practice, a very high proportion of patients have symptoms without physical signs or abnormal investigations. The diagnosis of patients' problems is more likely to depend on good history.

Symptoms are a form of communication and they are the patient's description of their perception of abnormal sensations. Although it appears to be subjective, we can still understand the meaning of a patient's symptoms by attentive listening, clarification of meaning through dialogue and avoidance of selection bias.

Original change in body state can be bodily expression of an emotion.

A elderly lady would sudden has chest pain after husband's funeral and the signal would be interpreted as the approach of death.

The extreme fear would generate more bodily changes such as tachycardia, sweating, shortness of breath adding to her anxiety.

If the doctor understands her context and explain her symptoms as expression of grief processed both cognitively and emotionally with increased understanding and lessening of bear.

The matter will be worse if she is attended by a doctor who just orders battery of tests to rule out cardiac problems with no communication.

Patients need to decide how to code the symptoms for transmission to doctors, including what language to use and which symptom or problem to mention first.

The decision can be influenced by many factors beyond health consideration. Often there are many symptoms or problems and often with emotions related to the symptoms such as anxieties, fears.

For elderly, how well they can code the information in verbal form depending on the availability of a language of familiarity.

The message coded in words have direct causal relationship with the sensation the patient is trying to communicate non specific sensations are more difficult to put into words especially vague complaints.

It seems that disorders that threatened the integrity of the personality are particularly difficult to find expression for.

Can you think of examples for elderly or adolescents?

If the presenting complaint is psychosocial, the principal problem is psychosocial most of the time. However, if the presenting complaint is somatic, only about 50% of the identified problems are somatic (Barack and Carpenter, 1983, J of Family Practice)

Patients tend to find other ways to overcome difficulties of expression. They would use indirect form of communication such as expressing personal distress through bodily symptoms.

However they are not imagining the sensations. They are simply selecting the aspect of illness experience that can be easily put into words.

Problems with shame or guilt like family and sexual problem are often communicated indirectly. They would present themselves for 'check up'. The most sensitive problem is likely to be left to the end and what we call 'door handle sign'. 'By the way doctor. I feel...'

Indirect communication protects against rejection on embarrassment. How patients codes personal distress to the doctors depending on their perception of how doctors receive the information. Patient centred approach will allow expression directly.

Family doctors needs to be very receptive to those little cues indicating what context the patient's message is encoded in.

Many of the illnesses encountered in family practice can only be understood by understanding their context.

Decoding is generating hypotheses for further testing and observation.

The following cues should alert doctor to the possibility of working in personal and interpersonal rather than the clinical pathological context:

- Frequent attendance with minor illnesses.
- Frequent attendance with same symptoms or with multiple complaints.
- Attendance with a symptom present for a long time.
- Attendance with a chronic disease that does not appear to have changed.

- Patient's distress is not compatible with the minor nature of illness.
- Failure to recover in the expected time.
- Failure of reassurance.

Think of recent consultation with your patient fitting one of the above categories. What is his or her real problem?

Listening

Active listening is best counseling . Listening with undivided attention is not easy as it require intense concentration on everything the patient is trying to say both verbally and non-verbally.

For example, a patient with advanced cancer says “I seem to need more morphine.” the doctor can reply, ‘Yes, you are on high dose.’ or doctor can say, “What are your concerns and worries?”

Discuss the difference of two different responses.

Listening

Doctor may be enquiring by direct question on chest pain the patient may raise a remark. “I often feel I could cry.” Doctor carries on question, “Does the pain go anywhere else?”

One will get an answer “No.”

Better if doctor just asks, “Do you have any worries?”

Listening Skills

Patient-centered approach depends on doctor's ability to elicit the patient's story in his/her own words so doctors have better clues to both the biomedical and psychosocial issues of major concerns.

How would you handle if patient is long winded and keep talking?

Initial open-ended, nor directive questions followed by focused, close-ended questions

Listening

Another common error is providing the answer before response of patients.

Doctor: How is your appetite? All right?

Patient: Yes.

Doctor: Your weight is OK?

Patient: Yes.

Doctor: How do you feel today, Mr. X?

Patient: (pause for 30 seconds then) Everything seems hopeless.

Doctor: Is there anything you can hope for?

Patient: I wish I would settle my children before my illness gets worse.

Listening

Gesture can have positive impact if appropriate such as leaning closer to patient or slowly nodding the head. It would make it worse if doctor keeps looking at notes or watch.

Silence can be facilitating so don't be afraid of silent.

Open-ended questions encourage expression

‘Where is your headache?’

‘Tell me more about your headache.’

Expression by the patient can be helped by some feedback. ‘You look upset’ or ‘You seem to be angry.’

Listening

A patient is unlikely to express his feeling to a doctor who is detached and cool.

Empathy is the capacity to enter into person's experience. In conventional clinical method, symptoms are tools for diagnosis of disease.

However we needs to see bodily discomforts as experiences to be understood in their own right.

Breaking bad news

Never tell patient something that is not true. Do not tell them more than they want to know. How do we find out what the patient wants to know!

We first find out what they know. They might know more than we think.

Breaking bad news

A study found that most patients knew that they were dying.

They wanted to discuss their feelings openly and without evasion.

If we ask, “What is your understanding of your illness?”, this gives good insight what patients know.

Breaking bad news

When a serious diagnosis is being conveyed for the first time, doctor will want to know how much information the patient wants.

One can ask, “Are you the kind of person who likes to know all the facts?”

Giving bad new for first time can cause pain and discomfort as it is unexpected.

One should avoid unnecessary addition to patient’s burden by insensitivity such as giving information in brutal fashion.

Breaking bad news

Doctor: "...we have got the results of your tests showing that you have cancer of large colon."

Patient: "What can be done?"

Doctor: "We are going to remove part of your colon."

Patient: "When?"

Doctor: "Tomorrow morning."

What do you think of this encounter?

Breaking bad news

The pain of bad news can be lessened if doctors show consideration of patients' feelings and take time to answer questions and reassure of continuing support.

The worst thing to happen is giving the bad news, then walk away.

Breaking bad news

A famous consultant chest physician told the patient. “There is a shadow on your chest X ray, we need to do a special investigation called bronchus copy to get tissue out for further test.”

Patient asked, “Is it a cancer?”

Consultant said, “Yes, very likely.” Patient, “Oh dear.” He was shocked. Consultant walked away.

Breaking bad news

Openness to indirect communication is important when talking to patients with serious illness. Patient may ask. “Is it serious?” or “Why do I feel more tired?” rather than “Am I going to die?”

“Do you understand about your illness?”

“Yes, I know I have cancer.”

“The disease will make your feeling tired.”

“Is it getting worse and progressing?”

“It is a progressive disease. One cannot state for certain how fast it will progress. However we can help the tiredness by relieving pain, ensuring you sleep well and having good diet.

Breaking bad news

The words we use in talking to patients depending on culture. One will avoid emotive words.

One important guiding principle in giving bad news is to try to find some reason for hope in every patient.

Not necessary hope for survival, it would be hope for living until a mission is completed or dying peacefully.

Communication Skills

Body Language

- Maintain eye contact
- What would be the difficult time in maintaining eye contact?
- Usually addressing sensitive issues and as sexual issues, family violence, psychological problem, etc.
- Avoid clicking a pen, looking at time, shuffles through papers, look at computer
- It is best to tell patients what information you are searching through papers or computer

Patient-centered Examination

- Continue verbal communication with patient so less threatening and also picks up some cues
- Maintain eye contact
- Attentive to facial expression

Patient Education

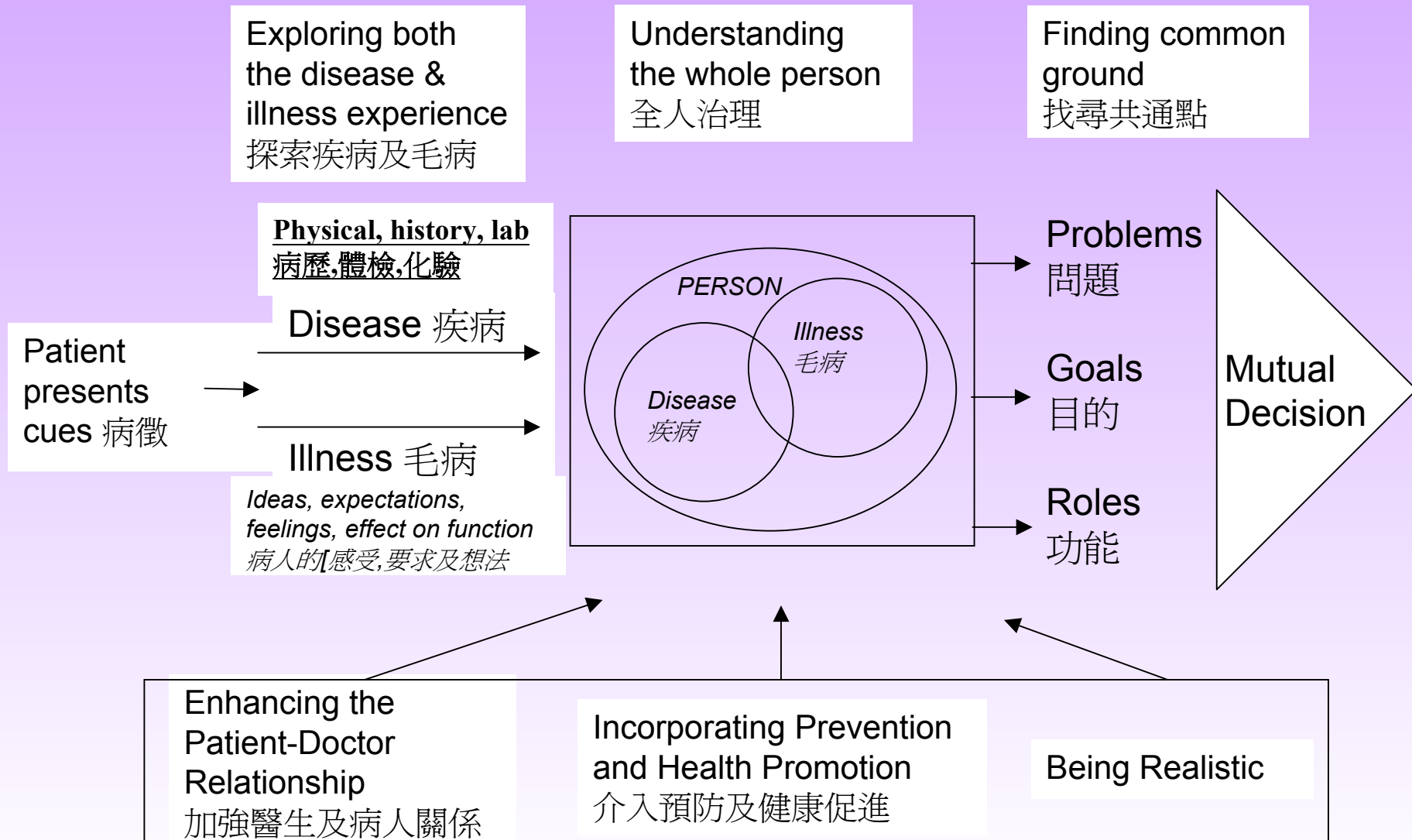
- Not just information giving
- Can discuss differential diagnosis more fully by explaining what parts of the history and physical examination supports or contradict a variety of diagnoses
- Psychogenic cause of illness is not simply by exclusion
- For complex treatment plan, further work up is needed
- Patient can only take in limited information at one time

Negotiation

- Physicians do not simply do whatever patients want to respect patient autonomy
- Accept patient choices that seem medically prudent and consistent with patients interest
- Think of some examples
- Work out a protocol what patients should do to monitor their problems

Patient-Centred Clinical Method

(病人為本的臨床方法)



Patients' view on screening for depression in general practice

K A Wittkampfa,b, M van Zwietenb, F Th Smitsb, A H Schenea, J Huysera and H C van Weertb

Family Practice 2008 25(6):438-444;

- **They found that all patients appreciated the active way in which they were approached for screening. Fifteen of the 17 patients recognized the depressive symptoms but nine of them did not accept the diagnosis. The first explanation for resistance to the diagnosis of depression is fear of stigmatization and skepticism about the usefulness of labeling. Secondly, patients experienced their depressive symptoms as a normal and transitory reaction to adversity. Thirdly, patients had doubts about the necessity and effectiveness of treatment. Depressive symptoms, such as feelings of guilt, self-depreciation and fatigue, hamper help-seeking behaviour.**

The researchers concluded: "...some patients with undisclosed depression, who took the trouble of going through a complete screening programme, felt aversion to being diagnosed as having depression. In the context of screening for depression, we recommend that the patients' view on depression be elicited before diagnosing and offering treatment."

