Effective doctor-patient communication in practice

Notes for students

Authors:

Eva Pozsgai MD, PhD

Boróka Gács PhD

Editors:

Ágnes Csikós MD, PhD

Éva Pozsgai MD, PhD

English Translation:

Vilmos Warta PhD

Alexandra Csongor PhD

Ágnes Csatlós

This is an extract from the following literature:

1. Silverman J (2013): *Skills for Communicating with Patients*. 3rd Edition. CRC Press. London
2. Von Fragstein M: *UK consensus statement on the content of communication curricula in undergraduate medical education.* Medical Education. 2008 Nov; 42(11):1100-7.

and based on the following literature:

1. Varga K (2013). *Hűtésbefizetés avagy: a szuggesztiók szerepe a mindennapi orvosi gyakorlatban.* 2. kiadás. Pólya Kiadó. Budapest.

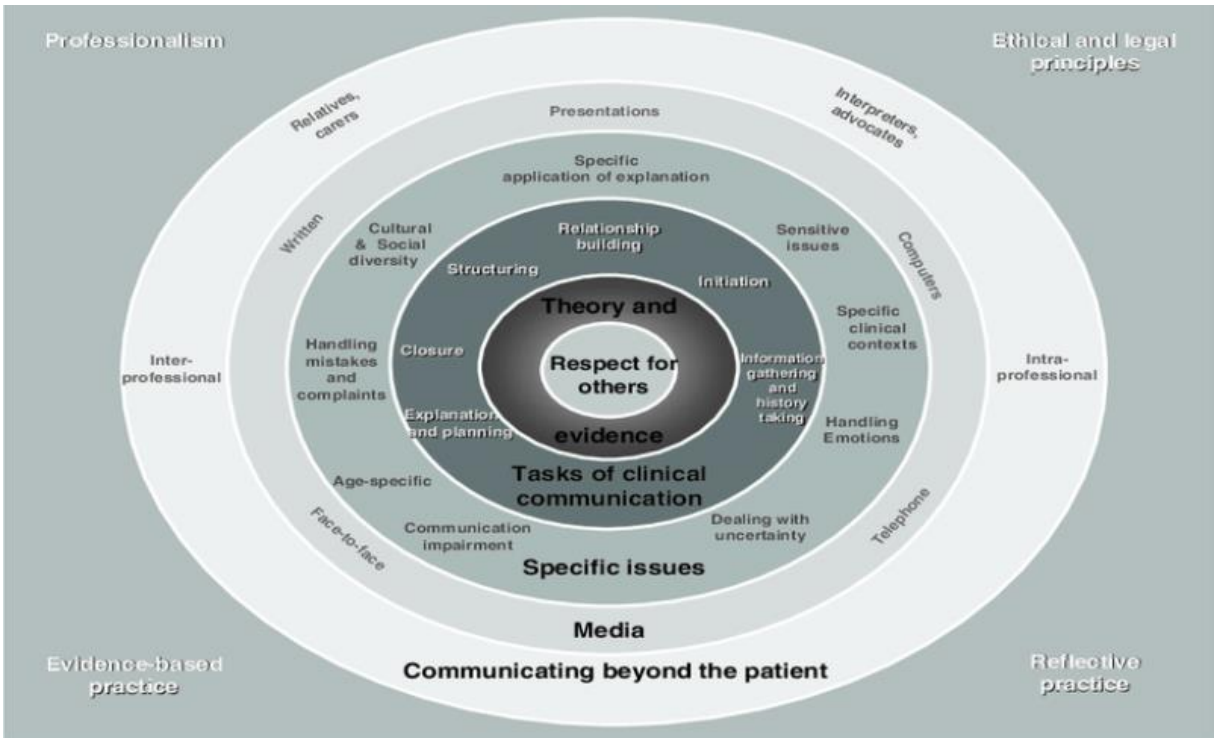
2. Varga Katalin (2011). *A szavakon túl. Kommunikáció és szuggesztió az orvosi gyakorlatban. Medicina Könyvkiadó*. Budapest.
3. Varga Katalin (2013). *Helyzet+oldások. Kommunikációs stratégiák kiélezett orvosi helyzetekben.* Medicina Könyvkiadó. Budapest.

Foreword

A critical component of clinical competence is communication competence. Assessing and improving one's communication skills is crucial for professionalism. The importance of a skills-based doctor-patient consultation model cannot be overemphasized.

Knowledge and practice of the basics of doctor-patient communication are essential. It is only with these skills that it is worth discussing the challenges of dealing with specific communication situations. The following guide is a generally applicable communication "core", on which the skills for dealing with specific communication situations can be further built.

The essential element of good medical communication is based on respect for the patient. Other features surround and support respect-based communication in a multi-layered manner, thus creating a body of communication knowledge. (Communication Curriculum Wheel), shown in the figure below.



1. figure: The Communication Skills Circle

2.

(Adapted from: Von Fragstein M: *UK consensus statement on the content of communication curricula in undergraduate medical education.* Medical Education. 2008 Nov; 42(11):1100-7)

Introduction

The clinical effectiveness of good doctor-patient communication is supported by numerous scientific studies (the text you are reding summarises a textbook based on nearly 300 literature references).

How does good doctor-patient communication lead to better clinical effectiveness?

- Effective communication results in a greater sense of support from the patient, a better outcome of the disease, improved patient and doctor satisfaction, and a healing relationship between doctor and patient;
- bridges the gap between evidence-based medicine and attention to individual differences.

Communication skills can be divided into three groups, which are inseparable and co-exist in all doctor-patient communication situations:

1. **Content-related skills:**
   Transfer of information from doctors, asking the right questions, etc.

2. **Process-related skills:**
   How is communication done? Verbal and non-verbal skills, open and closed questions, etc.

3. **Perceptual skills:**
   What the clinician thinks and feels: decision making, problem-solving, feeling empathy, respect for others, etc

A typical example is when the doctor asks closed questions (process-related skill) about the patient's complaints (content-related skill):

Patient: lately I have to get up often at night to urinate. Doctor: I see. *How many times do you need to urinate? Do you urinate with a weak or normal stream? Do you have difficulty urinating? Does your urine sting?*

Instead:

Patient: Lately, I often have to get up at night to urinate. Doctor: *Yes...?* Patient: I've been drinking more; lately, I'm often thirsty. Doctor: *Mm-hmm...* Patient: My mother was diabetic. Do you think I could be diabetic?

The concept of negative trance and suggestion

Knowledge of the concepts of negative trance and suggestion is essential for the knowledge and correct use of communication skills. Suggestions are defined as messages, usually verbal (but not necessarily!), that are involuntarily followed and accepted by the receiver and elicit a response that reflects the thought content of the communication. E.g., address, naming, signage, context, non-verbal cues, direct communication and questions

Any situation that causes increased fear, vulnerability, emotional stress, or inability to rely on our usual frame of reference because of novelty can result in a negative trance state. The most common example of this is the doctor-patient relationship, i.e. the communication situation resulting from the patient's vulnerable position. This is important because this situation is characterized by non-rational thinking, perceptual narrowing, the altered and extreme expression of emotions, increased importance attached to one's own subjective experiences and increased suggestibility. A person in a trance state can be highly susceptible to suggestion, sometimes following it literally. However, the suggestive effect is still present even if the suggested method is not known, and therefore the patient is unprotected against adverse suggestions.

The most important basic rules of suggestion:

- **Positivity**
  Positively state everything we can. "Relax" instead of "Do not tighten your muscles." or "Everything is fine./You are safe." instead of "No problem". Also, try to use phrases with positive connotations.

- **Repetition, rhythm and pauses**
  Repeat the positive suggestion several times, with several pauses, congruent and attentive to the reactions and processing.

- Do, **instead of trying** and use "when" instead of "if" (conditional)
  If we only assume something, it is not sure - that is, it adds to the uncertainty that already exists.

- **Knowledge transfer, informing**
  There is information on what is likely to happen but no discussion of possible adverse outcomes unless the situation requires it.

- **Providing an opportunity to increase the perceived sense of contol:**
  In almost all cases, the primary suggestion is the doctor-patient relationship. This includes using the plural form, asking for permission to speak and touch, offering multiple options for the patient to choose from.

The most effective types of suggestion and communication strategies:

- **Questions:** The questions suggest that the doctor can help and that an improvement in the patient's condition is expected:

  It hurts, doesn't it?" "Are you feeling terrible?" instead say:
  "Are you feeling any better?" "How can I help you?"

- **Direct suggestion**: we are clear and open about the message we want to convey.

- **Implications**: it is not stated, only implied.

  One of the most effective ways to get rid of your complaints is if…
  Meaning there are several other options.

- **Motivation**: why the patient should cooperate.

  "We will look at how effectively your body relies on the medicines you are given."

- **Yes-set:** We put forward several undeniable ideas or have a good chance of being accepted, and only then do we give the target suggestion that we want to enforce. The facts may be banal or truisms.

  "Isn't it beautiful today? (Yes.) Have you had breakfast? (Yes.) Did the family visit yesterday? (Yes.) Okay, I'm going to prescribe you some medicine to make you feel even better."

- **Tracking-tracing**: a principle of gradualism, first we follow the patient (e.g. validating emotions), even physically (sitting there or validating their fear), then, if we see them accepting, experiencing the attunement, we come up with the critical suggestion.

  "I can see you are still scared, no wonder, in this vulnerable position. Let's take a look at how treatment can help you recover as quickly as possible."

- **Double binding:** We provide a choice about the details of an issue:

  "Which arm do you want the blood pressure monitor on?"

- **Reframing:** we provide a different interpretative framework for something.

  "Pain means that the tissues are regenerating; you are in the process of healing."

- **Future orientation**, focusing on the goal: The attention stuck in the "here and now" is directed towards a positive purpose.

  "It could take months to heal because of the severity of the injury". Instead: "You could be working in the garden in the spring."

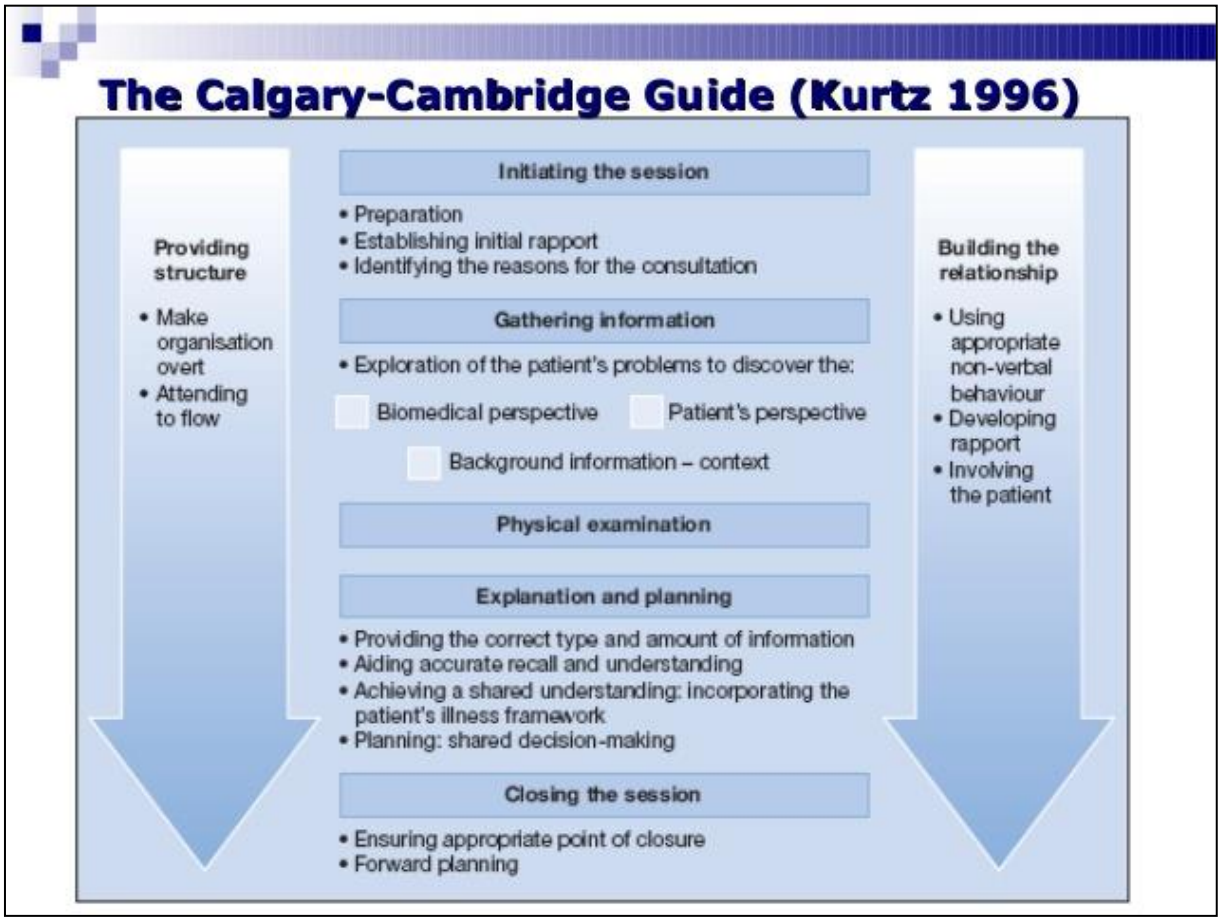
- **Anchoring or utilizing:** we use any circumstance that seems complicated or unpleasant. Use of sensory modalities.

  "The many machines and tubes you see around you and the strange smell all indicate that you are as safe as possible."

- **Model effect**: an example is given to the patient, e.g. a patient who has already recovered from a condition.

Learning the skills for effective doctor-patient communication requires a thorough knowledge of the steps in the guide and then regular application in daily practice. The use of positive suggestion rules and techniques in each step can be applied at any point, but it is primarily essential in building the relationship.

The following, the Calgary-Cambridge Guide provides a diagram of the schematic process. It is also an outline and an extension of the guide with examples. This is followed by a summary of communication techniques used in specific situations.



2. figure: Calgary-Cambridge Guide schematic process diagram

The Calgary-Cambridge Guide - overview

Communication Process Skills (1-56.)

1. Initiating the session (1.-7.)

Establishing initial rapport

The doctor welcomes the patient, introduces themself, shows respect for the patient.

Identifying the reasons for consultation

Recognizes the main reason for the patient's presentation. Listens carefully to the patient's opening statements. Asks about the patient's other complaints. Confirms the main points of the agenda with the patient.

2. Gathering information (8.-18.)

Exploring the patient's problems/complaints

Encourages the patient to tell their problems. Moves from open questions to closed ones. Listens to the patient without interruptions. Encourages the patient to express their complaints, notices verbal/non-verbal signs, clarifies if the patient's expression is unclear. Summarises from time to time. Uses simple, plain words, questions. Establishes the correct sequence of events, time.

Additional skills to understand the patient's perspective

Explores the patient's ideas, beliefs, concerns, expectations and the impact of their complaints on their life. Encourages the patient to express their feelings.

3. Structuring the consultation (19.-22.)

Make organization overt

After a series of questions, summarises what was said. Uses signposts to indicate to the patient where they are in the conversation.

Attending the flow

The conversation follows a logical sequence. Pays attention to timing.

4. Building the relationship (23.-32.)

Adequate non-verbal communication

Use of appropriate non-verbal communication. If doctor takes notes, it is done without interrupting the conversation. Shows a proper level of confidence.

Improving the relationship

Accepts the patient's opinion, does not judge. Is empathic and openly acknowledges the patient's feelings and point of view. Expresses support. Tactfully handles uncomfortable, embarrassing topics and situations for the patient.

Patient involvement

Shares their thoughts with the patient. Explains specific questions about the need for a physical examination. During the physical examination, explains the process and asks for permission.

5. Explanation and planning (33.-52.)

Providing the correct type and amount of information:

Gives the information in parts, checking that the patient has understood the information; assesses how much information the patient already has; asks the patient what other information they need; gives the information at an appropriate time.

Aiding accurate recall and understanding

Structures the explanation. Categorizes appropriately, uses signposts. Repeats and summarises. Uses common words. Uses visual aids. Checks the reception of information.

Achieving a shared understanding: Incorporating the patient's illness framework

Links the explanation to the patient's point of view. Creates an opportunity and encourages the patient to contribute. Perceives the patient's verbal and non-verbal cues. Takes patient's beliefs, reactions, feelings into account when making explanations.

Planning: shared decision-making

Shares their own ideas. Involves the patient in the decision. Offers several possible solutions. Assesses the extent to which the patient wants to be involved in the decision. Develops a plan that is acceptable to both parties. Checks if the patient agrees with the decision.

6. Closing the session (53.-56.)

Planning

Coordinates further actions between the patient and the doctor. Providing a safety net: what to do in case of unexpected results, symptoms or side effects.

Ensuring appropriate point of closure

Summary. The final check is if the patient agrees with the plan and has no questions.

The Calgary-Cambridge Guide - detailed

Communication process skills (1.-56.) with explanations and examples

1 Initiating the session (1.-7.)

A significant proportion of doctor-patient consultations fail because they are not started correctly. Before any doctor-patient encounter, it is crucial to prepare appropriately for the encounter and to define the consultation's objectives.

Preparation: the doctor puts aside his/her previous work (unresolved problems) pays attention to his/her own unmet needs (hunger, thirst...etc.).

1.1 Establishing initial rapport

- **The doctor greets the patient, introduces himself/herself** (name, title), **what his/her role will be in the examination/treatment of the patient, etc. identifies if he/she is talking to the right patient.**
- **Shows respect and interest in the patient**
- **Ensures the physical comfort of the patient** (e.g., sitting him/her down)

The relationship/rapport building starts from the introduction. The subsequent doctor-patient relationship can be easily established by giving the patient an opportunity to influence the process from the beginning, e.g. by asking how to address him/her. It is also important to talk to the patient when he or she is ready, e.g. already dressed.

If the introduction is omitted, it suggests the following to the patient:
1. the situation is too severe; there is no time to talk;
2. I don't care about your personality so I won't reveal mine to you.

!The first few sentences of the consultation are crucial for establishing the relationship!

!Make sure the patient is physically comfortable! Most people feel comfortable sitting in a chair, so do not talk to the patient lying, standing or sitting on the bed, except if the patient's condition requires it!

Good morning! I'm Dr Kovács, one of the emergency specialists at the hospital. You're Mrs János Szabó, aren't you? How may I address you? .... Okay, Elizabeth, please take a seat.
Good afternoon. I'm Katalin Varga, 5th year medical student.Your doctor, Dr János Kovács, said I could talk to you about your illness. Would you mind if I ask you a few questions about your illness first and then examine you before the doctor arrives?

The next step is to identify the reasons for the consultation.

1.2 Exploring the reasons for the consultation

The doctor recognizes **the main reasons for the patient's visit, listens carefully** to the patient's opening statements, does not interrupt the patient, **asks about further complaints, discusses the main points on the agenda.**

Examples of ways to detect patient complaints:

What do you want to talk to me about today? *How can I help you?* *What have you come to us/hospital/office/emergency room for today...etc.?* *Although I have read your GP's referral, can you tell me what you have come to see me about?* *How can I help?*

!If the patient has come for a check-up, do not automatically assume that you know what they have come for, but ask!

You came in for a blood pressure medication adjustment if I recall correctly, right? *I came to see if your wound was healing nicely. Is there anything else you'd like to talk about?*

! Most doctors assume -wrongly- that the patient's first complaint is their main complaint. Note that the listing of patients' problems does not necessarily indicate the order of clinical importance of the complaints!

!Since most doctors are time-pressed, they tend to interrupt the patient too soon, after the first 1-2 symptoms or phrases of the patient, with closed questions. The dangers of this are that the patient's further, possibly more significant complaints are delayed, and the doctor starts on the wrong track in making the diagnosis!

!Trust is also important early in the doctor-patient relationship because some patients only dare to mention their most essential complaints once they have established trust in the doctor!

!Therefore, it is important to let patients talk freely about their complaints - 80% of patients stop talking within 2 minutes.

What does it mean to listen to the patient?

Active attention, i.e. the doctor not only stores information from the patient but is also present on a psychological, social and emotional level.

How should we be present for the patient during the consultation, for example, when the complaints are listed?

- Wait for the patient, listen to what they say, don't think about the next question.
- Helpful reactions: encourage the patient to express their complaints to feel that we care about their problems. Simple phrases such as "umm..." "clear".... "really?.... "indeed".... "I see."
- Non-verbal communication: our body language, of which eye contact is an essential element, is a good indicator of our interest.

!Studies show that patients believe our non-verbal communication when the messages conveyed by verbal and non-verbal communication are not in sync!

- Recognizing and responding to verbal and non-verbal signals from the patient

Once the patient has been able to tell us why he or she has come (without the doctor interrupting tme!) and has gone quiet, we apply the **screening technique**. With the screening technique we can check if the patients have said all their complaints before moving on to the next part of the consultation.

Examples of the screening technique:

Doctor: 'So recently you've had frequent headaches and dizziness. Has there been anything else that has caused a complaint? *Patient.' Yes, and I"ve often felt tired in the afternoons, which has never happened before. Am I anaemic?'* *Doctor: 'So, you've also felt tired, and it occurred to you that you might be anaemic. Anything else?"* *Patient:' No, nothing else.'*

Screening should be used until the patient mentions no more complaints or problems. It is helpful to check again that the patient has been understood correctly.

Doctor: *So you've been experiencing headaches and dizziness recently and have been feeling tired more often, which you didn't before. You are worried that you may have anaemia. Do I understand you correctly?*

Often, patients will mention a problem they have not discussed before.

Doctor: *Understandably, you are concerned about these complaints, and of course, we will go into them in more detail, but first, I wonder if there are any other complaints that I can help you with?*

This check-up question is also important because the patient may even come up with "he/she has a persistent cough" or "he/she is concerned about his/her daughter because she is getting a divorce", which can be crucial in making the correct diagnosis.

!The importance of screening and monitoring is that it reveals openly, to both parties, the patient's agenda items that the patient would like the doctor to address during the consultation!

!During the clarification of the points, the doctor also has the opportunity to openly express the order of the agenda items he/she wishes to see!

Examples:

I would suggest starting with the fresh complaints of diarrhoea and fever, and then we can start with the blood pressure medication changes."

This is undoubtedly more than one problem that we should be addressing. I don't know if we will have time to do everything now. How about if we deal with your morerecent complaints now and leave the blood pressure medication adjustment for next time?

It's understandable that your joint pains have been making it difficult for you to move about recently and that this is bothering you, but if you don't mind, I will start by checking the chest pains that have been going on since yesterday. Can you tell me about this pain?

A good suggestive technique to explore the reasons for the consultation is to use positively phrased questions.

For instance:

"*What is your complaint?"*
Instead:
"How can I help you?"

and the yes-attitude:
"Good morning xy! May I call you by your first name? We'll start the rounds, shall we? Your family will be visiting soon, right? We'll be done by then."

Then the target suggestion, for example:
"You'll even have time to take your medication first! Please don't forget!"

2 Gathering information (8.-18.)

2.1 Exploring the patient's complaints/problems

The doctor encourages the patient to explain his/her problems; moves from open to closed questions; listens to the patient without interrupting; facilitates the patient's complaints; notices verbal/non-verbal signs; clarifies if the patient's expression is not clear; summarises periodically; uses simple, clear words, questions; establishes the correct sequence of events and time.

The use of suggestive questions and implications (hidden positive references) is the most important. It is important to highlight what works well besides the complaints. What is it that helps? What resources does the patient have that can help him or her and the doctor?

Example:

"What would help you to relax more easily now?" "What would make you feel more relaxed, talking to your family first or clarifying treatment details?" (implication: he/she will definitely relax, he/she will calm down)
"How great that only a few of the possible complaints/symptoms are present." (implication: his/her condition is better than what he/she is experiencing)
"Among your family/friends/acquaintances, who will be able to help you when you are back home?" *(*implication: you can go home soon)
"Listen to what you feel, what is happening, what will help when your pain/symptoms ease." (implication: the pain/symptom will be relieved)

In addition, deepening the relationship through empathic listening helps to strengthen trust and thus the effectiveness of subsequent suggestions.

In the information collection phase, we need to collect information from the patient according to three criteria:

1. **Biomedical perspective**
   Information about ILLNESS that can be proven by pathophysiological methods:
   the sequence of events, a summary of symptoms, information in the medical record.

2. **The perspective of the patient**
   SENSE OF ILLNESS: the patient's feelings, perceptions, expectations and impact on his or her life.

3. **Background information**
   CONTEXT: list of previous illnesses, medication history, drug sensitivity, family history, social, occupational history.

! During the traditional teaching of medical history taking, medical students are trained to collect biomedical (1) and background information/context (3). This attitude is reinforced by the fact that during examinations and referrals, young doctors have to tell their superiors this information and document it in the medical record!

! CAVE: a patient can have a feeling of illness even if his/her condition cannot be confirmed by pathophysiological methods. (e.g. severe headaches of a manager) OR a patient with no symptoms may have a disease (e.g. an asymptomatic patient screening reveals high blood saturation/ tumor) OR a patient has an illness but ignores the symptoms of a severe disease because of medically milder symptoms. (e.g. a middle-aged woman with pigment spots on her hands is worried about the spots, but she considers her bloody stools 'normal' (only due to haemorrhoids), not requiring further investigation)!

Suggested steps in biomedical history taking: ask the patient to tell the story of what happened to him/her, in order, "how did the complaints start?" Then clarify the symptoms listed (Where does it hurt? When does it hurt? Where does it radiate to? What is its nature? What is its intensity? What makes it worse? When does it subside? Related symptoms? patient's beliefs about symptoms?) Clarification of associated symptoms/complaints.

<u>Why is it important to take the medical history from both sides, the medical and the patient's point of view?</u>

- The doctor-patient relationship improves, and the aim of history taking is not focused on finding out the medical diagnosis but also how best to help the patient from the patient's perspective
- The traditional medical history does not explain the patient's problems. We can only help a patient presenting with hip pain if we understand what is causing him/her the most problems. We may recommend surgery when the patient does not want surgery at all, and is hoping for conservative treatment options. .
- Knowing the patient's perspective helps to set up the correct diagnosis. The 35-year-old female patient, who has had left squeezing chest pain since early morning, says she has been under stress lately and suspects fatigue. After the necessary tests have been carried out, she is relieved to learn that her complaints are indeed a result of stress and that the doctor is not just trivializing her problems when he sends her home saying, "all tests are negative, you have no heart disease, you can go home."
- The patient's perspective provides a basis for further planning and explanation of tests/treatments because it is the patient's perspective and opinion that can be considered when making further plans.

Example: A 55-year-old man comes to the clinic with chest pains, fearing he has a lung tumour because his friend recently died of the same disease. After being examined by the doctor, he concludes that the pain is musculoskeletal and sends the patient home with a painkiller saying "there's nothing wrong". Suppose the doctor does not ask the patient what he suspects about his symptoms, what he is afraid of, and does not explain why he does not think it is likely that the patient has a tumour. In this case, the patient will leave the surgery assuming that "the doctor may not have thought of the possibility of a tumour" and that a tumour could be causing his

symptoms. These doubts on the part of the patient may undermine the success of the treatment plan because the patient does not trust his doctor and does not accept the diagnosis or therapy.

Process of gathering information- HOW?

- **Exploring the patient's complaints:**

The patient tells the story of his complaints in chronological order: the doctor encourages the patient to explain from the beginning what happened to him, "how the complaints started". We start with open questions, which are not always real questions:

Doctor: *Let's start at the beginning and tell us how your complaints started...*

! If we ask closed questions, then, let's set an exact timeframe!

"Have you been feeling depressed?" Instead: *"Have you been feeling depressed since you hit your head two weeks ago?"*

Do not ask the first question when you are already thinking about the second!

- **Principle of thought**: moving from open questions to closed questions.

It is often a problem that the doctor switches to closed questions after 1-1 open questions too soon!

Doctor: *So you have a chest complaint - where exactly did the pain occur?* Patient: Well, here in the front. (points to the sternum) Doctor: *What kind of pain: dull or sharp?* Patient: Quite sharp, actually. Doctor: *Have you tried taking any medication for it?* Patient: Antacid, but it didn't help. Doctor: *Is there any other pain?* Patient: No, only at this point.

Combine it with a conversation with open questions:

Doctor: *Tell me a bit about this chest complaint.* Patient. The truth is, it's been getting worse recently. I've always had problems with my digestion, but not this bad. Here I get a sharp pain (points to the sternum), and then I burp, and I have this sour-bitter taste in my mouth. If I drink a bit of wine, it's even worse and interferes with my sleep. Doctor: *I see. What do you think is causing it?* Patient: Well, it occurred to me that it might be the medication I'm taking for my joints. My symptoms have been getting worse since I started taking this ibuprofen. Of course, I need to take it to move since my husband had a stroke.

!The two open questions gave the doctor more information than the four closed questions!

!Closed questions are like blindly trying to stab something in the dark; you don't know exactly where you're poking, so it's more effective to use open questions to define the place you want to poke. Closed questions only give us information about a narrow, limited area, and it is the responsibility of the questioner to define this narrow area! So be careful with closed questions and use them only in the right place and in the right amount (e.g. to clarify or filter information)!

!When answering open questions, we have the opportunity to focus on the answer and not just think about our next question!

! With open questions, we also get answers about the patient's perspective on their illness!

- **Active listening**
  The doctor listens carefully to the patient, does not interrupt, gives the patient time to think

- Helps the patient tell his/her story with **appropriate responses**: both verbal and non-verbal. Methods**:**
  - Encouragement: 'yep...' 'I see' yes' indeed...."
  - Silence: short silence after encouragement to allow time/opportunity for the patient to respond. If the patient gets stuck, you can say, for example: "I see that this is difficult for you to understand, but could you share your thoughts with me?..."
  - Repetition/ echo: Echoing the last thought the patient said.
  - Interpretation/ paraphrasing: the doctor paraphrases, as interpreted, the information and feelings conveyed by the patient. The aim is to make the problem concrete and determine whether the doctor has understood the problem correctly.
  - Sharing the doctor's thoughts with the patient helps to involve the patient..

Following the example of the previous consultation:

Doctor: *Tell me a little about this chest complaint.*
Patient. The truth is, it's been getting worse recently. I've always had problems with my digestion, but it wasn't this bad before. Here I get a sharp pain (points to the sternum), and then I burp, and I have this sour-sour taste in my mouth. If I drink a bit of wine, it's even worse and interferes with my sleep.
Doctor. *I see... What do you mean? (encouragement)*
Patient: Well, it occurred to me that it might be the medication I'm taking for my joints. Actually, my symptoms have worsened since I've been taking this ibuprofen. Of course, I need to take it to move about since my husband has had a stroke and I need to physically assist him.
Doctor: *(silence - eye contact - slight nod of the head)*
Patient: His condition has deteriorated a lot lately, and I don't know how I'll cope if he can do even less on his own and all the burden of caring for him falls on me.
Doctor: *Mm-hmm, would it all fall on you? (repetition/echo).*
Patient: Yes, because I promised I wouldn't take him back to the hospital, but I am not sure if I can keep my promise any longer.
Doctor: *So you are worried that if your husband's condition continues to deteriorate, he will not be strong enough to support him on his own? (interpretation/translation of the information)*

Patient: Physically, I think I could manage somehow, but what if he needs me 24 hours a day? I'm all alone, and I can't ask my daughter to help me because she lives 200 km away and raises her children alone."
Doctor: *You seem worried about disappointing your husband. (interpretation/interpretation of patient's feelings)*
Patient: Well, yes, because I love him very much and worry about him and myself.
Doctor: *It is quite understandable that you are worried, and your words show how much you love and care for your husband. (interpreting feelings, reflecting, legitimizing feelings) You are going through a difficult time. (small silence) It sometimes happens with patients that chest complaints are caused by stress exhaustion - do you think this could be a factor in your case? (doctor shares his thoughts)*
Patient: Yes, the truth is that I suspect a lot of stress is making my complaints worse because last week, when my husband had a fever, I couldn't eat, and the pain was much worse and lasted longer.

- **Recognizing and responding to verbal and non-verbal cues** (body language, vocalization, facial expressions, emotional state) given by the patient**:**
  The majority of patients want to tell us what they are feeling or thinking, but they give us indirect signals most of the time. We need to recognize and respond to these. Patient: "Well, yes, there was something...." "things have been a bit messy at home lately...."
- **Clarification**
  Clarifying ambiguous terms "Can you tell me what exactly you mean when you say you feel dizzy?"

- **Summarise in chronological order**

- **Partial summary**

At certain intervals during the consultation, the doctor will summarise what he or she has heard. The aim is to find out whether the doctor has understood the patient's complaints accurately, to summarise information that is important for the doctor to make a correct diagnosis, to gain the patient's confidence that the doctor has listened to him/her, to make the consultation transparent for both parties, to encourage the patient to provide more information

Staying with the previous example:

Doctor: *'Let me see if I've got this right: you've had digestive problems in the past, but recently you've been experiencing sharp pains in your chest, accompanied by a sour-taste in your mouth. Drinking alcohol makes it worse. The complaints make it difficult for you to sleep, and you have considered that occasional painkillers for your joints may be causing the pain. Do I understand you correctly? (Silence...)*
Sick: Yes, and now I can't afford to be sick myself when my husband has been in such a bad state since his stroke. I don't know how I'm going to cope.

- **Language**: clear, unambiguous, without jargon

2.2 Additional skills to understand the patient's perspective

Explore the patient's ideas, beliefs, concerns, expectations and the impact of their complaints on their life. Encourage the patient to express their feelings.

! Actively explore the patient's perspective:

- **the patient's idea of what might be causing the complaints;**
- **the patient's concerns about what worries/is most disturbing about the complaints;**
- **the patient's expectations, what the patient's goals are, what the patient wants the doctor to help with;**
- **the patient's thoughts and feelings about the complaints**
- **the impact of the complaints on the patient's life**

!Identifying these is important because the patient's perspective needs to be incorporated into the development of the treatment plan so that the doctor and patient can find common ground during the consultation!

!This does not mean that the patient's wishes should be fulfilled, which is unprofessional, but that the doctor and patient should develop a treatment plan together by listening to and accepting the patient's perspective. So, it is not necessary to prescribe an antibiotic if it is not professionally justified, but it is recommended to listen to the patient's point of view!

HOW to detect the patient's perspective?

- **Recognizing and responding to indirect verbal and non-verbal signals from the patient**

Repetition of signs in 1-1 words:
"upset...?"
"Could something be done...?"

Responding to the patient's verbal cues:
"You mentioned that you were concerned that the pain might indicate some severe illness. What do you think/what are you afraid might be causing the pain?
"You mentioned that your mother died of a heart attack. Are you concerned that you might have a heart condition?

Responding to the patient's non-verbal cues:
"I feel you are not fully satisfied with the previous explanations you have received. Am I right in thinking that?"
"Am I right in thinking that you are upset about what happened to your daughter?"

- **Directly, by asking for the patient's perspective**

Inquiring about the patient's beliefs:
Tell us what you think is causing the complaints?
What do you think might be happening?
Do you have any idea what might be causing it?
You must have been concerned about this problem a lot. It would help if I knew what you think might be causing it.

Asking about the patient's fears
What are you afraid of that might cause it?
Is there anything that particularly worries you about your complaint?
What was the worst thing you thought might be causing it?

Asking about the patient's expectations
What are you confident we can help you with?
What might be the most appropriate solution plan?
How can I best help you with this?
You must have dealt with this problem a lot. How do you think we could help?

- **Reacting to the patient's emotions: mirroring**

You mentioned that you felt miserable. Could you elaborate on what you mean exactly?

So you were angry...?

I sense that you were very tense. Would it help if you told me what the problem is?

You seem sad when you talk about your husband.

It must have been very difficult for you.

Can you remember a specific time when you felt that way?

Can you tell me how you felt at the time?

Thank you for telling me how you felt. It gives me a better understanding of your situation. Did you manage to tell me everything you wanted to?

I think I am beginning to understand how you felt in that situation. Now let's look at the practical part of the problem, how we can help.

In summary, the content of the information collection::

1. List of patient's problems/complaints (e.g. headache, dizziness, malaise)

2. Detailed exploration of the patient's problems:

- **Biomedical perspective**
  The sequence of events, symptom analysis
- **Patient's perspective**
  beliefs, fears, expectations, impact on the patient's life, feelings
- **Background information/Context**
  previous illness, medication history, sensitivity to medication, social and family history, exclusion or confirmation of the presence of significant additional symptoms

! These steps apply to ALL doctor-patient consultations, no matter how brief the interview or examination. Of course, the Background Information/Context information can be narrowed down as needed (e.g. for an already known patient, it is unnecessary to take a family history every time), but the ***patient's perspective*** *should be found out during every consultation!*

3 Structuring the consultation (19.-22.)

Structuring the consultation, as well as building the relationship, is a continuous process during the doctor-patient interview (2. figure).

3.1 Make organization overt

After aseries of questions, summarise what you have heard, using signposts to indicate to the patient where they are in the conversation.

HOW to structure a conversation?

The structure of the conversation is made clear to the patient (too):

- **Partial summary (during the consultation)**

  At certain intervals, depending on the content of the conversation, the doctor will summarise what has been said before. The aim is to ensure that both parties have the correct understanding before moving on to the next part of the consultation.

  If you can't think of anything else to ask the patient during the interview, it's best to summarise - this helps you pull your thoughts together and allows the patient to come up with information that hasn't been mentioned yet!

Doctor: *So, let me see if I've got this right: you've been having pain in both knees for a few months, mainly on exertion, and in the morning, you feel stiff in all your joints, especially your fingers, and you've also become tired?* Patient. And it's getting harder and harder to take care of my kids.

  With an internal summary, we give the patient another oportunity to express his thoughts, thus creating an effective two-way, mutual communication, instead of the one-way communication defined by the doctor!

- **Using signposts**
  Before moving on from one part of the consultation, use transition phrases to indicate the point and purpose of the further work/questions/investigations. Often an internal summary is introduced by a signpost.

Let me check that I have understood correctly - let me know if I have missed anything *You mentioned two significant problems: your joint problems, which are associated with pain, fatigue and stiffness in the joints, and then not knowing how you can manage to look after her children. Could we start by going into more detail about the joint complaints to understand the causes better and discuss the difficulties you have with your children?* *As I do not know you yet, it would be helpful to know about any previous conditions you have been treated for. Perhaps we could continue with this...* *I can see that you are not feeling well, and I will try to help you in a moment, but first I would like to know what medicines you are taking, and I would like to examine you quickly to understand better what is causing your complaints.*

! The signposts are useful because the patient knows what to expect, what, why and how to expect it, reducing anxiety! Furthermore, the consultation structure becomes transparent, manageable and the doctor is also asking the patient for permission to move on!

! Use signposts: when moving from introduction to information gathering; when moving from open to closed questions; within different parts (perspectives) of the history-taking; before starting the physical examination; when moving to explanation, planning; when closing!

3.2 Attending to the flow

You should conduct the conversation logically, paying attention to timing.

Paying attention to the flow of the conversation::

- Asking questions in a **logical order**

- **Timing:** taking into account the length of the interview, keeping the time allocated to the specific parts of the consultation

!Internal summarisation and signposting will also help achieve these goals!

Repeating positive suggestions are also vital in structuring the conversation, for example:

Congruent use of timing, pauses and pacing.
More frequent use of the word "**cure**" instead of "disease".

"There is nothing wrong."
Replaced by
"It will be all right."

"We'll give you medicine for your illness."
Replaced by
"We'll give you medicine to make you better."

"Don't worry; it's not that bad/ it's not that bad/ it could be much worse."
Replaced by
"All these people/ I am/are here to make you feel as safe as possible today. Rest assured that we are doing everything we can to help you get better."
"Your body is strong and seems to be responding to the treatment well."

4 Building the relationship (23.-32.)

4.1 Appropriate non-verbal communication

Appropriate non-verbal communication: eye contact, facial expression, body posture, proximity-distance, touch, movement, voice inflexion, intonation, volume, speech rate, appearance, environment.

!The difference between verbal and non-verbal communication is that verbal communication lasts as long as we are speaking, and non-verbal communication lasts as long as we are in the presence of the other person. Even in complete silence, we communicate non-verbally!

!We need to pay attention to our non-verbal communication because some of it is consciously controlled, but some of it is an unconscious form of behaviour!

!Verbal communication is used to communicate information and ideas. Our non-verbal communication is responsible for conveying our attitudes, feelings and moods!

! If the information communicated verbally and non-verbally does not match, the non-verbal information is considered more credible than the verbal information!

What are signs of the doctor's empathy? What type of non-verbal communication increases patient satisfaction?

- **Eye contact, arms held loosely** (e.g. not folded across the chest), **upper body slightly forward, voice tone showing concern/interest** (not bored), **lively facial expressions, mirroring** (e.g. mimicking patient's posture), **sitting posture** (instead of standing)
- If you are using a computer or taking notes, do so so that **it would not disturb the conversation**, show an appropriate level of confidence.
- **Notice and respond to the patient's non-verbal cues** (body language, speech, facial expressions, facial expressions, emotions)

- Suggestive elements of non-verbal communication:

  - Posture, a spatial position as an expression of hierarchy and control - "I am cooperating with you!"

  - Eye contact and undivided attention instead of a mobile phone - "I'm listening!"

  - Calm and attentive, slow, relaxed pace of speech - "Everything is fine!"

  - Touch - significant cultural and individual differences, it is important to ask permission! - "I respect your individuality and your privacy!"

4.2 Establishing a relationship

!Clinical effectiveness increases if we can develop a good relationship with our patients. Often by itself, a supportive doctor-patient consultation can be enough to bring about a cure!

Goal: To make the patient feel understood, valued and supported

See the suggestive elements used at the beginning of establishing the relationship.

"When you are healed, /you can go home/ you can stand up again." *"I would like to understand you better so that we can work better together and help you more effectively."*

- **Accept the patient's opinions and feelings and do not judge.**

Doctor: *So you are worried that a cancer might be causing your diarrhoea?*

! It is important that, when accepting the patient's feelings, we leave a few moments to allow the patient to react to what we have said and avoid sentences beginning with "Yes, but...".

!It is important that accepting the patient's feelings and point of view does not mean that we agree with everything the patient says!

Doctor: Oh, of course, people often have diarrhoea, which doesn't mean they have cancer. What exactly did you notice? Patient: Well, for the last two weeks, I've been having loose stools about three or four times a day, and before that, it was only once a day, and always with a normal consistency. Doctor: Oh, nothing to worry about yet. Instead: Doctor: *So you're worried that cancer is causing your diarrhoea?* *(short pause)* Patient: Yes, Doctor. My mother had the same symptoms when she died of colon cancer at 47. Doctor: U*nderstandably, you are worried; we will examine you thoroughly. Tell us a little more about your complaints, and then I'll check if everything is okay.*

!We can reassure the patient during the consultation that their complaints do not indicate a severe illness, but only in the second half of the consultation, when we have listened to the patient, and they feel that we have accepted their opinion and concerns!

- **Empathy:** openly and empathetically acknowledge the patient's feelings, situation and point of view, and respond to the patient's feelings.

Doctor: *It is understandable that you want to have this investigated.* *(pauses here for a moment, non-verbally indicating the patient to continue...)*

Patient: Yes, you see, Doctor, my mother died of colon cancer at the age of 47, and I remember that it also started with diarrhoea. I'm scared that I've got cancer too.

!It is not enough to feel empathy; you must also express it to the patient!

We must see the problem from the patient's perspective and express our understanding to the patient!

I can see that the death of your husband has been very hard for you.
I understand that this must be very difficult for you to talk about.
I sense that you are very upset about his illness.
I can see that you are very upset by his behaviour.
I understand that you fear that the pain may return.

(mourning her husband) Patient: I'm so angry with him; why did he leave me?! He didn't even write a will.
Doctor. *I suppose this upsets you a lot.*
(a few moments of silence to allow the patient to continue)
Patient: Yes, I am angry and upset. I'm mad that he left me, and I feel guilty about it. Do you think I'm crazy, Doctor?
Doctor: *These must be powerful feelings to deal with - Thank you for sharing your thoughts.*

If the patient does not express his/her feelings verbally, but only non-verbally: **we have to react to these feelings expressed in indirect ways.**

(oncologist) Doctor: *I sense you are stressed about being sent here. Am I right?.... It's completely understandable, and many people are anxious when they first have to come here.*
(silence for a few moments)

"I can see you're pleased that the results of the test were good. I'm happy for them too.
(silence for a few moments)

Expresses support, concern, sympathy and helpfulness to the patient, acknowledges the patient's coping strategies, offers partnership

(without continuing with "yes, but…")
Doctor: *Thank you for telling me - it is important for me to know what is worrying you.*

Expressing concern

I'm a bit worried that you are travelling home alone from here and won't be able to take care of your arm with your cast

Expressing sympathy:

I understand that you were upset that the surgery was cancelled at the last minute.

Expressing helpfulness

If there is anything else I can do to help, please let me know.

As I said before, we cannot cure cancer, but we can help you with your symptoms. So please let me know if there is anything you need.

Offering partnership:

As I said earlier, we need to work together to cure you from the disease. Let's think about the options we can choose from.

Acknowledging the coping strategies:

I see you have done your best to bring your fever down properly.

You have managed your symptoms very well at home, despite the severe problems you have dealt with.

Listening to the patient's feelings

I'm sorry if this test is a bit unpleasant. I'll try to get it over with quickly.

- **Tactfully handle** uncomfortable, embarrassing topics and situations for the patient, including a physical examination.

A good suggestion technique to respond to the patient's feelings is "**tracking-tracing**". By validating the patient's feelings (anxiety, etc.) and showing empathy, we can also guide them towards the goal.

"Am I right in seeing that you're still scared? No wonder, in this vulnerable situation. Let's look at how treatment can help you recover as quickly as possible. You are safe here."

4.3 Involving the patient

- **Involving the patient in the doctor's process of thinking**
  It aims to reduce the patient's anxiety. Sharing thoughts with the patient to promote patient participation. *"I'm thinking about...."*

"Now I'm thinking about how to find out whether the pain is coming from the arm or the shoulder..."

"Sometimes it's difficult to find out whether the abdominal pain is caused by some physical abnormality or perhaps by anxiety."

For example, the latter can be helpful because:

Patient: You may have hit the nail on the head, Doctor! My son and I are going through a tough time, and I just don't know how to cope.

! If the doctor just asks, "Have you been nervous a lot lately?" the patient might think: "Does the doctor think I'm a nervous wreck?"!

- **Providing explanation**
  Explain why specific tests (e.g. physical examination) or questions are necessary. Explaining the meaning of tests/questions if they give rise to misunderstanding:

Doctor: "How many pillows do you sleep with at night?" (this is difficult for the patient to understand why this is an important question) Instead: Doctor: '*When you lie down at night, does the choking become worse when you lie in a horizontal position? Are the symptoms milder if you sleep on more pillows?"*

- **Involving the patient in the process of the examination**

Asking for permission during a physical examination, explaining the procedure

The suggestive content of patient involvement gives the patient a sense of empowerment, strengthening their sense of control over their illness and situation. A good technique to use: **double-binding**

"Which arm would you like us to take blood from?" *"Do you prefer to take your medicine in the morning or the evening?"* *"Do you think two or three weeks of rest would settle your anxiety and health?"* *"Do you want your relative to be there during the treatment?"* *"Would you prefer to be seated or lying down for the induction of anaesthesia?"*

Building a relationship also involves closing it or transferring it. We can make the situation and work of colleagues or relatives easier by "handing over the rapport" with a simple suggestion at the end of the examination or visit.

"The night nurse will be here soon and will help you with whatever you need." *"I'll tell your wife/husband which medicines to take when to take them, so you'll be as safe as possible with her/his help."*

5 Explanation and planning (33.-52.)

5.1 Providing the right amount and type of information

Objectives: To provide the right amount and quality of information; to assess the patient's information needs, neither too little nor too much

! Effective communication is based on interaction rather than the direct transfer of information. The essence of interaction is that the transmitter of the information receives feedback on how the information was received and interpreted and how this influences the receiver's behaviour!

- **Deliver the information in small doses, checking that the patient has understood.** Take the patient's reactions into account when directing the rest of the conversation.

Doctor: *So, based on the typical symptoms of coughing at night or after physical activity, I suspect asthma, and I would prescribe medication...(silence for a few moments) Does that make sense to you so far?* Patient: Well, I think so. But I don't quite know what kind of disease it is, so is it contagious?

- **Assess the patient's starting point** (how much information they already have):

Doctor: *I don't know how much you've heard about diabetes?* Patient: Well, I've heard something about it because my roommate was a diabetic in college. Doctor: *It would be good if you could tell me what you already know about this disease so that I can expand on that.*

Assess how much information the patient wants to receive:

Medical psychological researches suggest that patients have different coping strategies. Patients who respond with vigilance (sensitizers) have a high demand for information when being informed. Patients who process anxiety-provoking information in a blunting (repressive) way, on the other hand, require less information, only the most relevant information. The vast majority of patients are sensitizers, but significantly not all. The need for information may also be related to the patient's current condition and situation.

The majority of doctors underestimate the need for patient information and do not consider that a minority of patients need less information!

Doctor: T*here's a lot more I could tell you about Parkinson's disease and the medication options. Some patients want to know all the details, and others are only interested in the basics. What level of detail would you like to hear about the disease?* Patient: Well, Doctor, I don't know how much more I can take today. Maybe we could finish the treatment now, and then next time my wife and I come back, we can go over some more things.

- **Ask the patient what other information they need,** e.g. aetiology, prognosis

Doctor: *Do you have any other questions that have not been answered?* Patient: Can my family members also get it from me? I mean, is it contagious?

!Previous studies have shown that doctors talk more about the treatment plan and medicines, while patients are more interested in the diagnosis, prognosis and causes of their illness!

Doctor: *So, your elbow pain is bothering you. I think you have a condition called tennis elbow. I believe that because... You probably developed it because... Unfortunately, it may take a few months to heal, but I don't think it's part of a severe condition, although I see you didn't know if it was severe either... What do you think about this?*

Give information at the right time; do not give advice, information or reassurance too early

For instance, when the information is given too early:

Mother of a patient: Anna has had a bad cough; shouldn't she be given antibiotics? Doctor. Anna's cold has only aggravated her existing asthma. So it's not the infection that needs to be treated, but the worsening of the asthma symptoms *(The doctor will then question the patient's mother in more detail. It turns out that Anna has been febrile for two days, and on physical examination, there is a weakened breath sound above the lung on the right side. The doctor tries to save the situation but has already lost the trust of the patient's mother)* Doctor: Well, even though Anna's asthma may have gotten worse, I think she will still need to take antibiotics.

Instead:

Mother of a patient: Anna coughs a lot; shouldn't she be given antibiotics? Doctor: *This is an excellent question. We'll discuss it in a moment, but first, I'm going to examine Anna.* (The doctor will then question the patient's mother in more detail. It turns out that Anna has been febrile for two days, and on physical examination, there is a weakened breath sound above the lung on the right side) Doctor: G*oing back to your question, yes, I think she will need antibiotics. Often, upper respiratory tract infections make asthma symptoms worse, but now Anna probably also has a bacterial infection in her lungs.*

5.2 Aiding accurate recall and understanding

The aim is to make the information more accessible for the patient to understand and remember.

!Say what you want to say, then say what you said!

! Previous studies show that patients remember only 50% of what doctors tell them. And even if some patients remembered more than this percentage, they did not understand the most critical information conveyed. Another problem is that they disagree with their doctor!

Signposts: Explanation that is easy to follow and remember, break down the explanation into parts, build up the message logically

Doctor: T*here are three essential things we need to talk about. First, I'll tell you what disease I suspect; then we'll discuss what tests should be done, and finally, we'll discuss the treatment options. So, first of all, I think you have what is called diverticulitis...*

- **Proper categorization,** highlight important information

Doctor: *The most important thing to do with your treatment is to take medicine regularly, every night, even if you were asymptomatic that day...*

- **Repeat and summarise;** to confirm that the information has been comprehended

Doctor: *'So, to briefly summarise: it's most likely a fungal infection on foot, which should be treated with this cream for two weeks. Apply it once a day to the site of the infection and if it doesn't improve or gets worse, we'll see each other in 3 weeks.'*

- **Use familiar words;** avoid jargon
- **Use visual aids,** written material, pictures, etc.
  These should only be used with the doctor's explanation, not on their own.
- **Checking the reception of information,** e.g. asking the patient, clarifying the information given

Doctor: *I know I've talked about many things, and I'm afraid I haven't been very clear. It would help me a lot if you could tell me what you have understood from all this information, so that I know whether the problem is clear to you!*

5.3 Achieving a shared understanding: Incorporating the patient's illness framework

Objectives: To explain from the patient's point of view, assess the patient's feelings and thoughts about the information given, and facilitate interaction rather than having a one-way communication.

!The fact that the patient remembers what the doctor has said does not mean that he understands or accepts the doctor's opinion!

!Information should be given from the patient's point of view!

- **Relate the explanation to the patient's perspective;** relate the explanation to the concerns, ideas, expectations raised earlier in the interview.

!The point is not to comply with the patient's every request - if he or she asks for a test (e.g. CT scan) or treatment (e.g. antibiotics) without medical justification - but to discuss openly what the patient wants. Then we can talk about how to reconcile the two positions!

Doctor: *You mentioned earlier that you were worried you were having a heart attack because your father died of a heart attack when you were young. I understand your concern about chest pain. Fortunately, in the light of my tests, I don't think it's a severe heart condition but rather a muscular pain. Let me explain why we can rule out a heart attack in your case...*

- **Enable and encourage patient input;** respond appropriately

Doctor: *Do you have any questions about this? Is there anything we haven't discussed?* ... Doctor: *Yes, indeed, this is an important question. I'm glad you asked it, I'll answer it right away-....*

- **Senses the patient's verbal and non-verbal reactions to the information conveyed,** e.g. concern, overload with information.

Doctor: *I see you are not happy with the possibilty of a surgical treatment - are you afraid of it?*

- **Take into account the patient's beliefs, reactions and feelings when explaining**.

5.4 Planning: shared decision-making

Objectives: To improve the patient's understanding of the decision-making process, involve the patient in the level of decision-making he/she wants to be involved in and increase the patient's adherence to the treatment plan.

!On average, 50% of patients do not take their medications at all or take their prescribed medication improperly!

! Shared decision making excludes the traditional paternalistic doctor-patient relationship but also the consumer-provider relationship that has emerged in recent years, where the patient goes from doctor to doctor until he gets the tests/treatments he wants. In the latter case, the practice of evidence-based medicine is not implemented!!

- **Sharing your process of thinking to the extent that isappropriate;** sharing ideas, thoughts, dilemmas with the patient

Doctor: T*wo possible diseases could be causing the complaints: either a stomach ulcer or gallstones. There are two possible causes. We have two options: either we start treating it with medicine as if it were an ulcer, or you have some tests done to find out exactly what's wrong...*

- **Involve the patient; outline options,** suggestions rather than instructions, offer more options

Doctor: *based on what you've said, I think two options would be better for you: either start hormone replacement therapy now or wait another week or two to see if your symptoms improve!*

- **Encourage the patient to tell their ideas**
- **Assess the extent to which the patient wants to be involved in decision-making;**

Doctor: *So, as I said, there are several options, both with advantages and disadvantages. Which would you prefer?* Patient response 1: Well, on the whole, I wouldn't say I like to take medication unless I have to. I'd rather wait a few more weeks and only start the medicine if the symptoms don't improve or: Patient response 2: Well, I don't know. What do you suggest, Doctor?/What would you do if you were me?

- **Develop a plan that is acceptable to both parties;** use signposts to indicate when to give his/her opinion of the therapeutic options, assess the patient's wishes

Doctor: *You must have thought about this a lot. How do you see the situation? What would be your first choice?* Patient: Well, actually, I'm worried about osteoporosis, but I wouldn't like to take hormone replacement medication. My friend was on a bisphosphonate. Is that an option for me?

- **Check whether the patient agrees with the decision,** whether the patient accepts the treatment plan, whether the doctor has listened to the patient's concerns

Doctor: *Let's see, is this treatment plan suitable for you?*

Doctor. *But if you feel it's not right for you, we'll have to think again. (If the patient confirms that they have an objection to the proposed treatment plan:) Tell me what you don't like about it?*

Doctor: F*rankly, I have some concerns about this treatment plan you'd like. I can explain why I don't think it would be right for you. I hope we can agree on a treatment strategy that we are both comfortable with.*

Summary of explanation and design objectives:

- -assess the type, quality and quantity of information to be given to the patient
- provide an explanation that the patient will remember and understand later
- provide an explanation that is relevant to the patient's perspective
- patient involvement, joint planning to encourage patient cooperation
- building relationships, providing a supportive atmosphere

Example:

Doctor: You need to quit smoking! You're playing with your life, you'll choke to deathif you don't stop smoking, and then I won't be able to help you!

Instead:

It must be hard for you to give up smoking; you are going through a difficult time with your family now. But unfortunately, your lung function has deteriorated a lot in the last year. I'm worried that it will worsen if you don't stop smoking. How can I help you quit?

It is in the explanation and design phase that direct suggestion has its strongest impact. It is therefore of paramount importance to avoid negative suggestions when providing information. Almost all techniques can be used well at this stage, and if the rapport is well established, it is at this stage that positive suggestions can be "flooded" into the patient.

For example, instead of raising the prospect of a negative outcome, **reframing** the complaints and the situation can be effective.

"The pain you feel is a sign of healing."
"The many machines and tubes you see around you and the strange smell are all signs that you are as safe as possible."

Future orientation, motivation, and model effects are also effective techniques in this phase.

"There is a long and painful recovery ahead of you." Instead: *"In the spring, you can work in the garden again in the fresh air."* *"Most people who undergo such surgery report a full recovery after just one year."*

If it is necessary to anticipate a negative outcome, it should not be specific to the patient but **general.**

"Do you want your wound to get infected?" Instead: "*Skipping antibiotic treatment can lead to infections that prolong the recovery time."*

Positive wording- Avoidance of the conditional mode and implications, i.e., hidden allusions, also play a significant role.

"Hopefully, there is a solution." Instead *"One of the most effective methods..." (not sure if there is a cure or if there are several effective methods)* "Don't worry!" Instead *"Everything is fine."*

The following two examples show a real-life case where a doctor gave instructions to an elderly female patient before she was given adenosine. The first example describes the words of a novice medical colleague, the second the communication of her doctor who, having had to repeat the treatment, tried to save the situation by positive suggestion.

"I'm going to give you a medicine that will *hopefully* bring your heart rate back to normal. As soon as I give it to you, *you'll feel pretty awful*, like you're going to faint, but don't worry, you won't. You'll also *feel terrible chest pains*, so it's quite uncomfortable, but it's still the best medicine, and because your heart is beating too fast now, *we'll have to stop it for a while."* Instead: "It was *almost perfect*. Did you *feel the medicine working* (reframing)? How do you feel now? It can indeed be a bit alarming *not knowing what to expect*, but the best thing is that you can *feel your heart rate returning to normal* (tracking and tracing). It's a strange feeling, isn't it? Most patients say it feels like a kind of shock, and they can feel their heart rate returning to completely normal (model effect). Everyone experiences it a little differently, but the common factor is that *it only lasts a few seconds in each case*, as it did in your case. So it is probably really best to repeat this medication as your heart seems to respond well to it (repeat). In the meantime, please pay attention to *how short it lasts.* 6 or 9 seconds (recovery, control experience)? I'll watch the monitor to see your heart rate (report)."

6 Closing the session (53.-56.)

6.1 Planning forward

- **Coordinate further actions between the patient and the doctor**

Doctor: *So, I'll write a referral to the dermatologist, to Doctor Kovács. In the meantime, you'll have the blood test results and can pick up the results in the lab in 2 days. Please bring the results of the dermatology and the lab tests in two weeks, when we next meet, to discuss the next steps.*

- **Safety net:** what to do if an unexpected result, symptom or side effect occurs

Doctor: the sore throat and yellowish plaque are signs of tonsillitis; I'm prescribing penicillin; you should take this for ten days; after a few days, you should feel better. (after three days, the patient still suffers from excruciating sore throat, goes to another doctor who gives an opinion on mononucleosis - the patient loses confidence in the first doctor's knowledge...) Instead: Doctor: *the sore throat and yellowish plaque are signs of tonsillitis; I'm prescribing penicillin; start taking it. If symptoms do not improve in 2 days or you develop a rash, come back for a check-up. Although the chances are small, it may be a virus causing your tonsillitis, and we may have to choose a different treatment strategy.*

6.2 Ensuring the appropriate close of the session

- **Summarise**

- **A final check** that the patient agrees with the plan and has no questions.

Doctor: *So, to summarise: your blood glucose levels have been slightly higher in the last three months than at your previous test. This is probably due to a dietary error during the holiday and that you have put on 3 kg. We have agreed that from now on, you will try to stick to your diet and try to get rid of the extra weight by walking at least 30 minutes a day. We will meet in 2 months, bring your blood sugar diary and see how you have improved. Is that okay?* Patient: Yes, Doctor. I think I've let myself go a bit lately. But now that I'll be walking our dog again from September, I don't think I'll have any problems with exercise.

Ideally, by now, all the patient's questions have been answered, but you need to make sure

Doctor: *Is that okay? Do you have any more questions?* Patient: No, thank you, Doctor. Thank you for your help.

!Problems at the end of consultation are often time-related problems. It is a typical problem that the patient brings up a new problem that has not been discussed before. It is due to mistakes made in earlier parts of the consultation (e.g. not listening to the patient's complaints)!

!Ask the patient if he/she has any further questions before the end of the consultation. You can do this with a signpost!

Doctor: *there you go... is there anything else you want to say?*

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