Effective Doctor-Patient Communication—A Hit or a Myth?

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My credentials for writing this article and The 20 Suggestions referenced herein include many years as a patient, 29 years as a psychology professor, and over 30 years as a clinical psychologist working part-time within the medical establishment.

As a psychologist, I’ve long been interested in the basic communication skills of physicians. On a personal level, I’ve been very impressed by the ability of my many physicians to communicate their concerns and a great deal of complex information during the course of very brief consultations.

Is my positive view regarding the communicative capabilities of physicians shared by other patients? Hopefully, yes; but maybe not. It’s possible that many patients have developed some unique and unrealistic notions regarding their illnesses and what to expect from their doctors. TV dramas, newspaper columns, advertisements, folklore, breaking news, and talks with other patients are among their influences. Patients may expect their physicians to be omniscient, omnipotent, compassion-compounded, and available 24/7. But in the real world of medicine, such persons are rare; and such unrealistic expectations could lead to routine disappointment for the patient and further complication of the physician-patient relationship.

Despite obstacles, most physicians probably believe they’re good communicators. That might well be accurate, but there’s always room for improvement. And a quest for such improvement can be an interesting and challenging project.

If a physician accepts this challenge, how should he or she go about it? A systematic inventory of one’s communication skills is a good start. Amid their strengths, most physicians can find a few habits that could and should be modified or even eliminated. Perhaps a mere “tweaking” of one’s communication skills is a responsible and reassuring first step.

Developed specially for physicians, The 20 Suggestions (available online at http://www.wisconsinmedicalsociety.org/_WMS/publications/wmj/issues/wmj_v111n2/111no2_20questions.pdf) can serve as a helpful resource for such an undertaking. Amid their strengths, most physicians can find a few habits that could and should be modified or even eliminated. While physicians are the focus for these suggestions, with slight modifications this approach could be employed by other health care professionals as well.

Ultimately, the usefulness of The 20 Suggestions will be determined by the experience of physicians and other professionals who are willing to try them out. Dr Thurston is a clinical psychologist and professor emeritus of psychology at the University of Wisconsin-Eau Claire who resides in Eau Claire, Wis. He can be reached at thurstjr@charter.net.
The 20 Suggestions

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Editor’s Note: The 20 Suggestions below are referred to in the WMJ “As I See It” column titled Effective Doctor-Patient Communication—A Hit or Myth? (Thurston J. WMJ. 2012;111(2); 49).

Introduction
While doctor/patient communication remains a most serious subject, The 20 Suggestions are phrased in a breezy, banter-laden, light-hearted style because I believe this approach increases the likelihood that these serious writings will be read and used.

1. First Serve
The doctor should take time to prepare for a first encounter with a patient. There is no second chance to make a good first impression. Aside from washing their hands and straightening their coats, what should they do? A smile, greeting the patient by name, and a firm handshake are a good beginning.

2. Listen, my children, and you shall hear ...
Some say that ordinary, everyday listening is a lost art. There is substance to that charge. Many people talk, but only a few really listen. With very real time constraints, there is no question that on a professional level, sensitive and insightful listening is very difficult to accomplish and sustain. The works of Groopman and Maynard attest to this.

“Allotted time” is an important consideration in the communicative process. Talking rapidly may get many “things” covered within a very short time. But a hurried approach may fail to communicate much of anything. If the physician is talking, he or she is not listening. If physicians don’t listen, they may come to know only a little about the psychological state or character of their patient. They may also fail to note important clues as the nature of any physical/psychiatric problems.

“Silence is golden” but in this age of “cost-effectiveness,” some clinicians would reject this notion out of hand; they may feel that silence represents wasted time.

Very important things may occur during the silent moments in a doctor-patient interview. It just takes time for some patients to feel comfortable talking. This is especially true if a patient doesn’t talk easily about anything and becomes absolutely tongue-tied regarding sensitive, personal issues. While some patients will never loosen up, they are more likely to do so in a laid-back, relaxed atmosphere. This is difficult to accomplish while working under the constraints imposed by a tight schedule.

3. KISS
The KISS principle is common in other quarters that deal with communication, rehabilitation, and choices of lifestyle: “Keep It Simple, Stupid.” As conveying information is the major purpose of the doctor/patient dialog, the doctor should select 3 or 4 basic, essential facts that he or she believes a patient must understand in order to be well-served. “Basic” and “understand” are key words. A mistake could be made if the doctor “assumes” (see Suggestion 8) that a patient understands a simple, basic concept that can then be built upon. Without basic understanding, the resulting elaborations by the physician may be so much gibberish; a mish-mash of information that the patient finds confusing, unsettling, and overwhelming.

Patient feedback is essential. Then, and only then, will the doctor be able to hazard a guess as to how successful he or she has been in communicating basic information. It would be helpful for the doctor to say, “Now, tell me, in your own words, what I have just said to you.” The answers may be shocking, disheartening, or reassuring. If needed, subsequent statements by the doctor may be directed at expansion or correction of what has not been conveyed clearly and fully. If the patient has truly drawn a blank, it may be necessary to start all over using a different approach. If at first, you don’t succeed, try, try again.

4. It ain’t what you pour out of the pitcher, it’s what gets in the cup!
Perhaps only a few patients—probably a very precious few—are able to understand completely all the unvarnished facts that pertain to their condition. (See Suggestion 5.) However, many patients might feel the need to create that impression. They do this to avoid offending the doctor or appearing stupid.

The doctor isn’t dealing with an empty vessel. Patients have all manner of well-entrenched ideas about themselves, their ailments, their presenting problem and doctors. And while there is a great likelihood that some of these views are erroneous, they are not so regarded by the patient. Even if the physician were fully aware of these entrenched viewpoints, “talking a patient out of these ideas” could be an exasperating and unsuccessful waste of time. “A man convinced against his will, is of the same opinion, still.” The roots of these beliefs are often very deep and not amenable to change.

The effectiveness of models, drawings, pictures, computer representations, and other
props in “communicating” is exaggerated. What is “plain as the nose on your face” to the doctor as he or she uses them, may be as mysterious to the patient as the Sphinx that has no nose. From a patient’s standpoint, their complexity might become part of the blur that is a failed dialog.

The new role of the omnipresent computer demands extended study and consideration. It portrays results and opinions concisely and clearly. However, it can be something of a “third party” that interferes with basic communication. For openers, eye contact between the doctor and the patient, an essential in interpersonal communication, is clearly diminished. In a way, that which is portrayed on the screen becomes the patient, a third party to be understood and treated.

In addition to the above considerations, patients often have a strong psychological need to deny the reality of their illness and what they must undergo as part of their treatment. As one attempts to understand others, there is no denying the importance of denial. When these powerful psychological needs are operative, they further complicate the conduct of an effective diagnostic interview.

5. An empty pitcher does not guarantee a full cup!
This is an elaboration the position introduced in Suggestion 4. If the doctor senses that the patient doesn’t understand something, he or she must resist the temptation to keep talking, telling the patient more and more of what the patient didn’t understand in the first place. “Do you have any questions?” is an insufficient means of determining what the patient really understands. If the patient shakes his or her head “no,” he or she may not understand enough to pose a meaningful question. If the doctor doesn’t consider this as a possibility, he or she may plunge ahead at great length, exploring new ideas, positing all the outcomes, including “worst case scenarios.” The doctor may then be “as pleased as punch” by this tour de force, satisfied that he or she has done a good job communicating. However, the doctor who believes this will often be deceived. The patient may become cowed, and will remain uninformed.

I believe two stories are at least vaguely related to some of the above:
A) A preacher, as he prepares his Sunday sermon, pencils in a reminder alongside one of his passages: “Argument weak, yell like hell!” If the doctor begins to feel that he or she is not getting through to the patient, he or she should avoid any “upping of the ante” of force in the presentation. Examples may include a more serious and determined repetition of things that were already said, louder and more strident expressions, and stern eye contact designed to get the complete attention of the patient. If this takes place, the patient will be cowed and will remain uninformed.

B) A father responds feverishly to a question by his 10-year-old son. “Dad, where did I come from?” For the father, this is a moment of truth. The embarrassed, unsettled, and perspiring father rattles on for a half hour in an effort to answer that question, “explaining” all about boys, girls, sperm, ova, menses, the necessity of protection, VD, etc. It is at the end, and only at the end, exhausted, he finally runs down and asks an important question, one he should have asked up front. “Why did you want to know?” The boy replies, “Well there is this new kid at school. He says that he came from Detroit. And I wanted to know where I came from.” Forceful answering of unasked questions is a waste of time.

6. The only way to consume an elephant is one bite at a time.
This applies to any doctor’s attempt to educate a patient. Modest goals should be set initially, moving ahead only when it has been demonstrated that these goals have been achieved. The process might be described as proceeding with glacial speed in the absence of glacial certainty. Never overestimate the patient’s ability to understand and assimilate new and unfamiliar material.

This also applies to a patient’s acceptance of his or her diagnosis and treatment. It takes time for patients to understand their circumstances. They must be allowed to believe it is OK to take their time.

Some patients may be shaken to the core as they begin to realize fully all that is involved in their diagnosis and proposed treatment. If a treatment program involves 42 daily radiation treatments stretching over many weeks, replete with all manner of possible significant negative side effects, this could pose a formidable, intimidating future for the patient.

However, if the patient is encouraged to “take it one day at a time,” or “one step at a time,” these daunting pronouncements become far less threatening and more “doable.” The next step should be made clear by the doctor, scheduled in the form of an appointment. If the patient is accepting of this approach, what is a daunting goal may become a bit easier and more attainable. The patient will be able to focus on the next step, then deal in sequence with the ones that follow. “A journey of 10,000 miles begins with a single step.”

Psychological reassurance in the form of proper back-up/assistance should be provided; the patient should know exactly what to do if he or she experiences problems. The clear-cut certainty of such immediate help might do much to undercut any need to seek it out.

7. Patois Patter
As doctors “walks the walk” with their patients, it becomes necessary to “talk the talk.” They must become conversant in the language of their patients. There is a danger that doctors, immersed in their medical practice, will come to rely unduly on the language of medicine. To patients and many others, this may be incomprehensible jargon. It becomes mandatory, as a professional responsibility, for doctors to become knowledgeable regarding current slang and local idioms. If they don’t, they may deny themselves important information from their patients. From time to time, both doctor and patient may be speaking in a foreign language to the one another. (See Suggestions 3, 4, and 5.)

8. A Checkered Life
In any patient contact, there are some essentials that must occur. These
might be questions asked, diagnosis and prognosis discussed, medications prescribed, appointments scheduled, and/or other matters. On what are probably rare occasions, some of these inadvertently might be omitted. The reasons could involve the doctor’s fatigue or boredom with routine. Unexpected events and materials could distract him or her from some essentials. A checklist, prepared in advance, might be helpful. It need not be read to the patient. But it could provide focus for the doctor/patient interchange. And this routinely would lead to an orderly transmission of essential information.

9. Making an ‘ASS out of U and ME’
Assume nothing! To assume anything important about a patient without making inquiry and/or gathering corroborative evidence is to run the risk of making major mistakes. Humility on the part of the physician has a lot going for it. It is thoroughly acceptable to admit that: (1) the doctor may lack a full understanding of patients and their circumstance, and/or (2) patients may have only a hazy idea of what the doctor is trying to communicate.

10. Semper Paratus
Always be prepared for the likelihood of the unexpected. To paraphrase Robert Burns a bit, “The best laid plans of mice and men often go astray.” When interacting with a patient, the doctor always should have a back-up strategy in light of changes—a Plan B or C. Who knows what might develop? The doctor might have devised an opening strategy that just didn’t work. He or she should be flexible and roll with the punches. While perseverance is a virtue, “perseveration,” ie, to keep repeating what is not working, is an exercise in futility.

11. “Doctor, Be Thyself”
No doctor should formally “program” or “script” any of his or her doctor/patient interactions. Doctors are, first and foremost, human beings, not robots. They should behave naturally. They should do nothing involving a patient merely because they are “supposed to.” After considering a full range of interpersonal techniques, they should then use those which they can employ comfortably and naturally. If they have difficulty doing the things they know work very well with other doctors, they might then ask “why?” and set about to find the answer. That sort of thinking is helpful in achieving both personal and professional growth.

12. Winging It
Doctors should feel free to stray from the “straight and narrow” on occasion as they attempt to capitalize on their own unique strengths. As long as The Hippocratic Oath is in place and observed, such ventures should be encouraged. They could lead to the personal and professional growth of the individual physician. Thinking and acting “outside the box” on occasion have led to some truly remarkable medical discoveries in the past.

How do doctors detect blind spots in their professional performance? Unless they are committing glaring errors, their colleagues and associates might be reluctant to point them out. “Fine tuning” requires some objective means of identifying any subliminal “soft spots” in a doctor’s performance. After all, if the doctor already knew about them, he or she probably would have taken steps to correct them. Highly pertinent psychological test information, notably of the sentence completion variety, could easily be elicited from patients. Some doctors might be reluctant to make such inquiry. But for those seriously interested in personal and professional growth, occasional reflection is mandatory.

14. Protectionism
Few know better about the pressures doctors face than the staff surrounding them. Ever “busy,” doctors may appear harried and unhappy from time to time. And, with the best of intentions, their staff members may set about to set this matter straight. Staff take it upon themselves to deal with what they regard as humdrum details, those that might otherwise interfere with the doctor’s concentration on more important matters. They may thus ward off an occasional nagging or rambunctious patient. They may delay contacts or communications that the patient believes are crucial to their own well-being. There is a possible downside to this well-intentioned protectionism. The doctor might become insulated and isolated from those very patients who need his or her personal attention the most.

15. Multiple Personalities
When two or more doctors become involved in one patient’s case, it becomes imperative that they communicate clearly with one another—and then, most importantly, with the patient. Otherwise, as they may come from different backgrounds and disciplines, their messages to the patient might be confused and confusing. They should arrive at something of a consensus as to how to proceed. They should speak as one. And the patient must be able to comprehend and accept what is said. He or she shouldn’t have to reconcile any differing views and opinions expressed by these doctors. It would be helpful to have one doctor designated as the primary spokesman.

16. “Talkabouts”
These are regularly scheduled meetings, perhaps held every 3 or 4 months. Topics would center about doctor/patient communication, ie, The 20 Suggestions, what has been attempted by way of improvement, how successful these efforts have been, any new problems, any new solutions. There is no need to wait for the next Press Ganey testing to provide impetus to such discussions. If there is interest, attendees could discuss the writings by Groopman, and then enter into spirited discussions about the results, their validity, and the practical implications. Catharsis and collegiality are encouraged in such exchanges.

17. Outspoken
Groopman’s words may have sent shock waves amongst the multitudes of patients. In his publication, physicians get anything but rave reviews. According to him, misdiagnosis and consequent mistreatment may run rampant. Patients who believe him might have a problem developing and maintaining any
meaningful trust in their doctors. Although Groopman claims he points out shortcomings so as to produce improvement, it is not at all clear as to how this would be helpful in the real world of medical practice.

Are there physicians who would challenge the negativity of Groopman’s position? Practicing physicians have a vested interest in refuting the charges leveled against them. How many of them will step forward to do so? If there are none, why is this? Many would opt out because they are “too busy.” But even the busiest of physicians could find time if they considered some response mandatory. Do they lack a forum? Very probably. Do they need one? Yes.

The title of this suggestion has something of the double entendre about it. It could be a call for physicians to “peak out boldly and candidly about this issue. Or it could mean that they are already “out spoken” in the sense that anything that they might have to say remains unspoken, that the stage has been surrendered to others with louder voices availing themselves of broader forums.

18. Anger Management
At times, the doctor’s frustration is the name of the medical game. One such time occurs occasionally when the doctor attempts to “fully inform” a patient regarding the diagnosis of and prognosis for his condition and the patient may not understand or may be belligerent or disturbed. It’s imperative physicians take it easy—with themselves as well as the patient. But “burnout” may be an occupational hazard.

Expressing or suppressing anger and frustration is counter-productive. Acceptance, albeit a reluctant acceptance, is the only way to go. Oft times, there is no alternative. The physician must settle for what can be achieved even though that may seem like precious little.

Yet another source of frustration for physicians occurs when they have “gone all out” for a patient. They have tried everything—exhausting themselves as they have exhausted every possibility. And yet, the patient fails to convey any awareness or appreciation for what has been done for him or her. Indeed, such a patient might repeatedly and loudly proclaim his dissatisfaction with “the sub-standard care” accorded him by “over-priced” and “incompetent” physician “who he is saddled with.”

Doctors must realize early on that they are seemingly destined to be a disappointment to some of their patients. It could have something to do with personality, credentials, or professional conduct. But all too often, “the fault, dear Brutus, lies not in our stars ...” but in the eyes of the beholder, the patient. Unrealistic, unwarranted patient expectation is central to this problem. Patients want more from their doctors than they can consistently deliver.

Patients really want to be treated by a Dr. Marcus Welby, a fictional TV character portrayed by the late Robert Young. Dr. Welby was all-knowing, all-caring, and always available. The enlightened and compassionate concern he provided a single patient was impressive to the point of being overwhelming—and unbelievable. To do what he did routinely would have required that his practice be limited to a single patient. And he did everything by himself. He never showed any need to rely upon any nurses, fellow physicians, professionals/ paraprofessionals, or other resources.

In real life, of course, there are no Dr. Welbys, doctors who could be depended on to solve all of their patients’ physical and psychological problems. And there never were! But, patient denials notwithstanding, this is the kind of physician that many patients continue to want and think they need. It is small wonder that they find themselves routinely disappointed by the services provided.

19. “Let It All Hang Out”
The previous suggestion dealt with the understanding of the frustration and anger often experienced by the doctor. This suggestion deals with the emotional reactions of patients to the information supplied by the doctor. This communication may be, on occasion, very threatening and unsettling. Perhaps too often, patients, particularly men, feel a need to minimize the emotional impact this has on them. Although they may be close to psychological collapse as they leave the examination room, they feel impelled to “keep a stiff upper lip” while in the doctor’s presence. Doctor should do whatever is necessary to undercut and eliminate this reaction. They should “grant permission” for their patients to express fears, frustrations, anger, and depression. Such cathartic expressions can be a great help to patients.

20. Touch and Go
Although we live in an age when any physical contact with a patient might be construed as a sexual overture, “the touch of a healer” should never be underestimated. A doctor’s warm, welcoming handshake or an arm across his departing patient’s shoulder can do wonders to reassure a patient, to convince him that he is being treated by a compassionate human being who genuinely cares about him.

Reality Check
In light of all the possible problems areas described in The 20 Suggestions, it seems remarkable that so many doctors are so consistently able to transmit a great deal of complicated information and counsel to their patients.

Reference