

What Are Our Goals in Communications with Our Patients?

There is a vast body of literature describing reasons why patients or families sue physicians: a common theme revolves around problematic doctor communication skills that leads to patient/family dissatisfaction with the doctor-patient relationship and consequent litigation. Beckman et al. examined plaintiff depositions and found problematic relationships to be the reason for the deposition in 71%; devaluation of patient or family views accounted for 29%; poor delivery of information, including insensitivity in the manner of information delivery, accounted for 26%; physician failure to understand the patient or family perspective accounted for 13% (1).

The purpose of the above paragraph is not to advise physicians or other health care professionals how to avoid malpractice suits, of course, but rather to emphasize the crucial importance of examining the goals of health professional-patient/significant other communication.

In this practitioner's experience there are 2 primary goals in our communications with patients/significant others; assessment, validation and support of their emotional needs; and assessment and support of their medical information needs.

This note will focus initially on the assessment and meeting of emotional needs. In the author's experience, in the absence of true psychopathology, most "difficult" patients appear to be those who's emotional needs have been ignored.

Case:

John was a 60-year-old gentleman with hormone refractory prostate cancer, widely metastatic to bone. He had been attending the Cancer Institute for a number of years and during this time his connection with his family doctor had lapsed. He had recently been admitted to the Cancer Institute due to uncontrolled pain and was shortly thereafter transferred to a tertiary palliative care unit, where his opioid therapy was switched to methadone. He was discharged from the PCU in good symptom control.

About one month later the community palliative consult team received a referral for symptom assessment and management advice about his increasing pain and nausea.

As the palliative physician entered the house the homecare case manager had also just arrived and was setting up a clodronate infusion. The palliative physician quickly sensed an emanation of hostility from both the patient and his wife, who appeared very close to tears. She angrily indicated that they had just had to pay \$160 for this clodronate drug. They made several references to the mismanagement of health care in general and threatened to complain to their MLA.

If you were the health professional in this "difficult patient" situation, what would you do next?

The palliative care physician asked herself "What is really going on here?" "Why are they really behaving this way?"

All charts and assessment tools were put away and with her body language portraying full concentration and concern the physician asked "Has something bad happened? Has something very distressing happened?"

John revealed that, as had been his custom in the past years, he had called the Cancer Institute to pose some questions to the RN working with his treating oncologist. She

obtained his chart and passed on to him that it documented that he had been discharged from active treatment from the Institute and that his future care would be in the hands of his family physician.

John wept. "What do you think this tells us? It tells us I've been written off. I've been seeing my cancer doctor for 5 years and he doesn't even think I'm worth enough to tell me this himself. How do you think this makes me feel?"

After a considerable period of allowing John and his wife to express their senses of hurt, anger, disrespect and disregard of them as persons and of their dignity, abandonment and helplessness their emotions stabilized. Medical assessment confirmed that the onset of his escalating physical symptomatology coincided with this call to the RN.

How can we attend to and meet patient/family emotional needs?

By listening, by simply being "present", by establishing "human-to-human" doctor-patient relationships, and, most importantly, by the technique of empathy (2). This technique does not refer to sympathy, compassion, caring, kindness. It refers to a cognitive skill: "...the accurate understanding of the patient's feelings by the clinician and the effective communication of that understanding back to the patient so that the patient feels understood..."(2). Suchman et al., on examination of transcripts and video-tapings of MD-patient interviews, found that patients seldom verbalized emotions directly unless invited, that MDs mainly allowed both clues and direct expressions of patient affect to pass without acknowledgment and returned to the preceding topic (commonly diagnostic exploration of symptoms). Some patients did attempt repeatedly to raise emotional topics, often with escalating intensity, without success in obtaining physician willingness to explore their emotional needs (2).

In the case above the physician cognitively focused on the emotional distress cues emanating from the patient and his wife, listened intently, tried to analyze accurately the emotions involved and directly reflect these analyses back to them to confirm that their emotional distresses were being fully understood. The appreciation of John and his wife was overwhelming. By the end of the consult his pain and nausea levels had subsided substantially. They stated they would never fully recover, however, from the emotional damage they sustained.

Non-Verbal Communication

Remember the utmost importance of non-verbal communication, both in health professional behavior and in assessment of patients or significant others.

Fuller Spectrum of Goals of Communication

The above discussion has focused on the importance of patient/significant others' emotional needs and ways to ensure that they are attended to but, of course, the spectrum of goals of communication is much wider. The author's reflections on this full spectrum are summarized as follows:

- 1) Ascertain the patient's level of understanding re his/her medical condition and prognosis. No communication with a patient can be optimal if the clinician does not have this information.
- 2) Ascertain the patient's level of desire for medical information. Customize the delivery of information to this. Forced truth telling is no longer considered compatible with the ethical goals of beneficence and non-maleficence.

- 3) Ascertain the patient's level of desire for participation in decision-making. Again, customize participation to the patient's desire and level of tolerability, honoring the ethical principle of patient autonomy.
- 4) Ascertain the patient's level of desire for inclusion of his/her significant others in information dissemination and participation of decision-making.
- 5) Complete steps 1, 2, and 3 with respect to the significant others.
- 6) Develop understanding of the "personhood" of the patient. What is the meaning of this illness to this patient? What is this patient's personality, coping strategies, spiritual landscape, goals, priorities, values? What is the nature of this patient's suffering?
- 7) Ascertain the patient's and significant others' support networks (professional and lay caregivers). Provide interventions to optimize these.
- 8) Using the above information, inform.
- 9) Using the above information, enable coping and integration of reality (3). The same information may have to be given more than once before reality can be integrated. Remember that "denial" can be an important coping mechanism and that the integration of reality is a process, not a one-time event.
- 10) Using the above information, try to facilitate decisions that are in the patient's best interests. But always remember patient autonomy.
- 11) Attend to all players' emotional needs, to enhance their sense of personhood and dignity (4).
- 12) Using all of the above, establish a "therapeutic alliance" with patients and their significant others and relationships that are "mutually sustainable" (5) over the indefinite long-term.

Dr. Anna Wreath Taube

References

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