Doctor-Patient Communication

Introduction to series

Marie-Thérèse Lussier, MD, MSC **Claude Richard,** MA

Of all the tools in your kit, the interview is undoubtedly the one you use most often. In fact, if your practice is like that of most general practitioners, you will conduct some 5000 interviews in the coming year[1] and spend about 1250 hours talking with your patients.

You might think, quite rightly, that nothing comes more naturally than talking and that you do not need special training to communicate with patients. In fact, to attain the objectives of professional communication, you probably have to make changes to your personal style. Communication skills can be learned and can be used to great effect. They are the focus of this new series.

Training is limited

Since the shift to greater reliance on technology in medicine and until quite recently, interview training generally comprised just giving young physicians a list of questions to ask their patients. Once they had memorized it, they developed their individual communication skills through trial and error. The method proved its worth over time, and most experienced clinicians were able to develop their approach by transposing skills learned in everyday life to clinical consultations. While most physicians manage quite well, they probably could communicate better. Both patients and communication specialists agree that there is room for improvement.[2]

Although communication training programs have improved since the 1980s, especially in family medicine residency programs, more progress can be made. The importance of communication with patients is now generally acknowledged, but during residency, the focus is on acquisition of other skills. In medical circles (particularly in hospitals), training in interview techniques and patient-physician communication still has a strong "psychosocial" connotation and is considered less relevant to the work of physicians.

Notable outcomes

Observational studies have demonstrated that effective communication influences certain outcomes of care.[3-5] Problems identified by physicians have greater congruence with those reported by patients; patients are more compliant with recommendations; patients recall information better; monitoring of physiologic variables, such as blood-pressure and blood-sugar levels, is improved; patients are less anxious; and patients and physicians are more satisfied with visits.[6]

Quality of information

The quality of the information physicians gather in consultations is closely related to their ability to question patients and establish relationships with them. Between 60% and 80% of the information needed to arrive at a diagnosis in primary care is obtained during patient interviews.[7,8]

Every student of communication knows that effective interviewing relies on techniques that are both flexible and systematic. Experienced clinicians

Dr Lussier *is a family physician, and* **Mr Richard** *is a psychologist, in Montreal, Que.*

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also know how important it is to elicit information that is as complete and accurate as possible. The methods for achieving these goals are known, have been systematized, and can be learned, so while being a born communicator is an asset, it is definitely not a requirement.

In the articles in this series, we will illustrate a particular perspective both on communication and on physician-patient relationships. We will identify the characteristics of such relationships so that physicians can use them as a guide to action. In discussing communication, we will therefore also deal with relationships between patients and physicians. We want to do more than just help you communicate better with your patients. We want to help you develop better relations with them.

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The medical interview

Setting, nonverbal language, and social roles

Marie-Thérèse Lussier, MD, MSC **Claude Richard, MA**

A paper on medical interviews or doctor-patient communication might be expected to start with an examination of the first words a patient and a physician speak to each other. Communication experts tell us, however, that the words people exchange are only one element in a complex system of communication.[1] A great deal of information is also derived from the physical context of the discussions, the social roles of participants, and the clues provided by their clothing and nonverbal behaviour. Before delving into conversations between patients and physicians, therefore, we look at the setting in which their exchanges take place.

Physical context and the message it conveys

Communication between patients and physicians begins long before they actually say anything to each other; their behaviour is informed and influenced by the physical context in which the dialogue takes place.[2] We can grasp the effect of physical context if we look first at professional communication outside usual hospital or clinical settings and think of the wealth of information physicians on house calls gather about patients before a single word is spoken. The neighbourhood and its surroundings, the type of dwelling and its

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exterior condition, and the way the interior is organized speak volumes about the person the physician is about to meet. Similarly, patients begin "to get acquainted" with physicians as soon as they call for an appointment or arrive at the clinic.

In most medical clinics, the physical set-up (secretarial area, waiting room, and physicians' offices) is geared to function and efficiency. The chairs lined up in rows resemble most transit lounges. Waiting rooms are, at best, places for killing time; certainly, no one would want to spend any more time there than necessary. They are very often impersonal and, indeed, are meant to be "neutral," but they consequently provide little information about the medical consultation to which they are supposed to introduce patients, the vision that guides the medical practice, or the beliefs that underlie and legitimize it.

Contacts with secretaries are similar to contacts with the physical environment: functional and efficient. Secretaries at reception who manage the files, telephone calls, and appointments no doubt appear very busy, and this image sends a signal that, unless patients are invited, it is inappropriate for them to remain at the desk for any length of time.

This atmosphere can be reinforced by the way physicians' consulting rooms are organized. For instance, in some walk-in clinics consulting rooms have no chairs; patients are ushered into a cubicle and immediately asked to sit on the examining table. Combined with a crowded waiting room, this arrangement carries a very clear message: we have work to do here, and we must be efficient. On the other hand, another, more classic feature, a desk placed between patient and physician, can contribute to the perception of a hierarchical distance between them.[3]

When the interview begins, patients in such environments tend to be in a particular frame of mind and feel called upon to be as accurate and concise as possible. A physical set-up oriented toward function and efficiency is thus surely inconsistent with so-called patient-centred interviews. Communication studies[3] teach us that, when faced with divergent verbal and nonverbal messages, people tend intuitively to believe more in the nonverbal ones. By extension, and especially when a patient's time with a physician is short compared with the waiting time, physicians must remember that the physical arrangements generally favoured and the way work is organized will give patients the message that efficiency is the predominant concern.

Nonverbal communication

Physicians can, albeit despite themselves sometimes, transmit a whole series of nonverbal messages that signal that they are important and very busy people. Nonverbal communication includes physicians' comings and goings, discussions with staff, and telephone calls.

More generally, how physicians dress communicates information regarding their social status, experience, level of culture, and even opinions. A physician's lab coat, shirt, and tie are not merely clothing; they also have a "social" meaning.

Social roles

Particular situations and people's differing roles in them help structure communication between them. Many of our social relationships are largely predetermined (eg, the way we address judges, police officers, or physicians in the course of their work is governed by norms that, while operative, are not always explicit). Examination of an unclothed body by a stranger is acceptable as part of a medical visit, but entirely unacceptable in other types of social encounter. During medical consultations, physicians and patients usually conform to the social roles expected of them in that situation. Any deviation from expectations can lead to uneasiness and dysfunction.[4]

Conclusion

In our view, the type of physical setting described above is congruent with a biomedical approach. If physicians favour a patient-centred approach, they are trying to convey a message that has no basis in the rest of the communication process. Attempts to insulate verbal exchanges from the context in which they occur give rise to inconsistencies that risk undermining the messages physicians want to transmit.

Let us imagine the sort of setting that would advance the human dimension of care.

- In a comfortable waiting room, patients find information on medical practice, the nature and functioning of the human body, and the care offered. A mission statement by the clinic reinforces messages about the type of relationship physicians want to establish with their patients.
- Secretarial staff are sensitive to patients as people.
- A comfortable office has a real sense of being "lived in" by a physician and has a place for patients.
- A contact period is reserved for each patient by avoiding numerous interruptions (telephone calls, discussions with staff, etc).

Bottom line

We believe that changes to the office setting would tell patients they are important as individuals and that doctors are listening to them. Physical context and nonverbal behaviour can contribute positively to doctor-patient communication.

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