Doctor-patient communication tricks. Oncological study at Campus Bio-Medico University of Rome

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Abstract

Objective: doctor-patient relationship is a very important variable in the oncological clinical consultation.

Methods: we have analyzed 100 outpatients oncological visits (first visits and follow up visits). We conducted an observational study of the extra verbal communication (non-verbal and para-verbal) with a structured observation grid. We have analyzed the three stages of the visit: 1. Patient’s admission, 2. Communication flows and 3. Information exchange between doctor and patient.

Results: In the first visit doctor introduce himself (85%). In the follow-up visit the doctor has received the patient with a handshake (86%) while in the first examination in 100%. In the follow-up visit the short phase of pleasantry was present in 61% of cases, while in the first examination in 45% of cases.

Doctor drawn an outline, a design or wrote a note in 45% of first examination and 25% of the follow up.

Conclusion: extra verbal communication is more important than the verbal. We suggest useful tips on what “do not” and what “do better” during clinical consultations.

Practice Implications: Against what is often believed eye contact is not always necessary or useful in establishing a good doctor-patient relationship it depends on the patient’s preferred representational system. Clin Ter 2018; 169(5):e224-230. doi: 10.7417/CT.2018.2083

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Introduction

Patient–doctor communication is one of the most significant component of the healthcare consultation, with ramifications for patient satisfaction (1), adherence to treatment (2), conflict resolution (3), laboratory costs (4) and clinical outcomes (5).

Cancer patients are exposed to several stress situations at the time of diagnosis and during treatment (6). Surveys conducted at the Memorial Sloan-Kettering Cancer Center outpatient clinics have found that between 20% and 35% of patients demonstrate a significant level of distress (7).

Empathy has been demonstrated to improve patient satisfaction, adherence (8) and an intrinsic therapeutic effect. Thomas reported a significant correlation between response to information needs and a reduction of treatment-related anxiety (9).

Ley P. found out that 36% of patients do not remember their doctors’ information about prognosis and treatment, 70% of them incorrectly assume prescribed medications (10).

The US Institute of Medicine endorsed effective clinician–patient communication as a central component of high-quality healthcare. The Committee on Quality of Health Care in US and other key organizations have identified communication skills as an important competency required for physician graduation in the US. Growing evidence also suggests that strong provider–patient relationships can have intrinsic effects on healing (11).

Walzlawick (12) defines some basic axioms in his “theory on communication”. The first and most important axiom is “One cannot not communicate”. Every behavior is a form of communication. Behavior does not have a counterpart (there is no anti-behavior), it is impossible not to communicate. Even if communication is being avoided (such as the unconscious use of nonverbal or symptom strategy like sleepiness, headaches and drunkenness), that is a form of communication. Even facial expressions, digital communication and silence can be analyzed as communication by a receiver.

Mehrabian and Ferris (13) say that para-verbal (14) and nonverbal communication (15) influence on the listener is respectively 38% and 55%, while the verbal aspect represents only 7%.

Argyle, later, repeated the Mehrabian’s experiment with a much more complex methodology and purpose, the effect of nonverbal communication was 12.5 times more powerful in speaker’s communicating attitudes than the verbal ones (16).
A majority of the relationship is set up through exchange of nonverbal cues and they may convey more of the emotional aspects of communication, with the more technical aspects (knowledge, competency) represented by verbal behavior (17).

Several papers reported that doctors underestimate the patient information’s desire in 65% of the consultations.

During the 20 minutes of consultation, a little more than a minute is spent to provide information to the patient (18).

In patients presenting cancer disease, the cognitive disability associated with stress may also exert a significant impact on the psychological health of the individual and even deteriorate the clinical diagnosis (56).

Computer and communication

Computer is essential in clinical practice. Patients worldwide express concern about computer’s use during consultation especially about the fixation of the physician’s eyes on the computer screen (19).

Electronic Healthcare Record (EHR) has a deleterious effect on communication, data show that the first few minutes of the “patient-physician” encounter have changed with the introduction of computers in the examination room. The EHR’s use (20) imposes several new pressures on the lines of communication between the physician and patient, especially the nonverbal aspect (21). With the computer present, the first minute of the consultation is often taken up with the physician interacting with the computer rather than interacting with the patient or discussing the patient’s agenda (22).

Margalit (23) found out that the physicians spent an average of 24% to 55% of the visit time gazing at the screen, and this time was inversely related to the physician’s engagement in psychosocial question asking and emotional responsiveness (19).

Computers and other associated devices often create a physical barrier. A large number of study demonstrated that gazing at the EHR screen was inversely related to physician engagement in emotional responsiveness and psychosocial exchange during the visit (23).

Duke has published a skill-based approach to optimizing the outcome of the physician-patient-computer interaction (24).

A possible strategy to overcome this problem is to divide the encounter into patient- and computer-focused stages. Signposting (telling the patient what you are doing as you transition to the computer) will signal that you are making a shift but still attending to his or her needs. Reading back what you have written, and then looking at your patient, also demonstrates active listening, and also keeping patients engaged by sharing the screen with them or reading out loud while typing (23, 25).

The importance of communication

Ineffective communication generates side effects such as an imperfect adherence to doctor’s instructions and, in the absence of significant results, patient dissatisfaction.

The combination of poor clinical results and the sense of dissatisfaction about the relationship established with the doctor is a formula that can directly lead to a legal court.

Doctors’ nonverbal communication (eye contact, head nods and gestures, position, and tone of voice) (26) has been associated with improved patient satisfaction and understanding (27).

Wrong communication, as well as lawsuits, may also lead to violence on healthcare operator (28). The deteriorating relationship between health-care providers and patients has made doctor turn into a dangerous job and have effect of the employment orientation of the future medical students (29).

Wrong communication also brings patients not understand the doctor’s recommendation and underestimate or overestimate the received indications (30).

Some classic errors are:
- To not introduce yourself at the first visit;
- To not shake patient’s hand;
- Back leaning constantly in his chair;
- Standing doctor vs sitting patient;
- Move the body and pelvis in different directions than the patient while talking with him;
- Crossed arms (unless it is not the patient having already crossed - or to have their legs crossed);
- Doctor stays in absolute silence;
- You start a palpation without telling to the patient that you’re going to touch him;
- Muttering (without make himself understood) while performing a palpation (it does not allow patient in taking part of what you are doing);
- Looking at the computer screen and typing on the keyboard in silence;
- Never look into the patient’s eyes;
- Use a language “away from” instead of a “versus” language;
- Disqualify the patient using a too much technical and specialized language, often interrupting and not responding to his direct questions;
- To not feed the hope.

Wrong communication can also badly influence the process of assessment of pain (that someone sees as a clinical art and a social communication) (54). In the CROMa taskforce (Coordination of Research on Osteonecrosis of the Jaws) of the Department of Oral and Maxillofacial Sciences of “Sapienza” University of Rome, communication has an important role in giving relevant informations and advices both to patients and to specialists prescribing therapies considered at risk of Medication-related osteonecrosis of the jaws (MRONJ) (55).

Effective communication

Patient perception of physician empathy contributes to patient well-being with improved physical and emotional health reported in patients who think their physicians care for them (3, 31).

Both verbal and nonverbal communication behaviors demonstrate attentive listening. These cues include non-
verbal behaviors such as eye glance and affirmative head nodding.

Eye glance is critical to observe emotion and distress in a patient. If the provider is gazing at the computer, he can miss this key aspect of the relationship (32).

Verbal skills that demonstrate active listening include “continuers” such as “Uh-huh,” “Go on,” “I see”; echoing statements; short requests such as “Tell me more”; and short summarizing statements, all of which can accompany typing on the computer.

During a consultation, a sitting posture alone is unlikely to compensate for poor communication skills. Assessing patient preference to physician posture and following their preference, can be a simple way of improving communication and thus patient outcomes, especially in oncology patients (26).

Sitting down during the patient interview does several things. It “slows down time”, it brings the physician to the patient’s physical level, increasing eye contact (standing physician posture has been perceived to be more dominant) (33).

Sitting physicians were preferred and viewed as significantly more compassionate than standing physicians while delivering bad news (34-36).

Finally, several studies indicate that ineffective communication often leaves patients feeling anxious, uncertain, and dissatisfied with care, suggesting the need for more patient-centered consultations (37, 38).

By contrast, effective physician-patient communication (39), involving adequate assessment, information giving, and support to patients, is associated with lower anxiety levels in patients with cancer (40-42) and instills confidence in the patient.

Methods

We have studied the nonverbal and para-verbal aspects of oncologist’s communication skills in the Campus Bio-Medico University Hospital (UCBM).

The study took place at UCBM’s oncology clinics from May to June 2014. The sample was 100 outpatient visits, including 20 first examination and 80 follow-up visit. We have done this survey according to a structured observation method. We used an observation grid designed to study some relevant nonverbal and para-verbal communication aspects:

- Environment-orientation in space;
- admission: introducing, shaking hands, pleasantries;
- volume, tone and speed of voice;
- doctor eyes contact;
- amount of speech-number of questions done by patients;
- hand gestures;
- diagrams, drawings, notes;
- posture and body movements: crossed arms/legs, torso forward/backward, basin direction;
- time of the consultation.
- Of 100 visits examined, 7 were carried out without patient’s presence but with his caregiver.

Results

We have analyzed three steps: 1. Patient’s admission (and the caregiver presence); 2. Communication flows during the interview; 3. Doctor-patient information exchange (drawings, diagrams, patient’s questions).

Step 1: The entrance

We have analyzed some items, the first is: “Approaching patients – introducing yourself”.

Data analysis showed that during the follow-up visit in 83% of cases doctor didn’t introduced himself (but he already knows his patients), while in the 17% of cases, in which he already didn’t know patients, he introduce himself in 16% while 1% did not.

In the first examination, the doctor introduce himself in 85% of cases, while he did not in only 15%.

The second item we have analyzed was the “Handshake”: in the follow-up visit the doctor has received the patient with a handshake in 86% of cases, while in the first examination in 100%.

The third item we have analyzed was “pleasantries” and “greetings”, otherwise the first “verbal approach” that introduces the full conversation. In the follow-up visit the short phase of pleasantries was present in 61% of cases, while in the first examination in 45% of cases.

Step 2: Communication during the interview

During the medical consultation we analyzed those parameters: torso, arms, pelvis and legs.

- In the first examination we have identified:
  - 75% of forward upper body
  - 70% of cross-legged
  - 60% of pelvis in the patient’s direction
  - 40% of the basin towards the pc
  - 35% of backward bust
  - 10% of crossed arms

- During the follow-up visit the posture assumed by the doctor was:
  - in 66% of the time the basin was in the direction of the patient
  - in 54% the bust was forward
  - in the 45% cross-legged
  - in 34% the basin was in the PC’s direction
  - in 7% had crossed arms

Both in the first examination that in the follow-up visit the voice synchronizations was present in 80% of cases. The flow voice synchronizations in 57% of visits; 50% of first examinations were done with synchronization on the volume of the voice, while doctors are synchronized in 60% of cases with patient's posture (nonverbal), 36% (follow-up visits) and 30% (first examination) of doctors are also synchronized on patient gesticulation.

Eye contact: Against what it is believed, eye contact is
not always necessary or useful in establishing a good doctor-patient relationship (43).

We noticed that in most cases the doctor's glance is still directed to the patient, with a 65% for the first examination and 80% for follow-up visits while the doctor's glance is directed mostly to caregivers only 2% of cases in the follow-up visits and never in the first examination.

**Step 3: Exchange information**

We found that doctors draw an outline, a design or wrote a note in 45% of first examination and 25% of the follow-up. The first outpatient examination lasted 22 minutes (average) while the follow-up visits lasted 18' (average).

**Discussion**

We started from the hypothesis that conversation is a variable key of the therapeutic alliance. The psychological reaction to the cancer news is a multistage subjective process (shock, reaction, processing, reorientation).

Without discounting the need for physician technical expertise in the field of cancer, oncology patients face specific emotional and psychological issues requiring additional physician emotional support (44).

Multiple studies in oncology patients have revealed that patients perceive physicians seated during the medical interview to be more compassionate, caring, and likely to spend more time with the patients.

There is no universal teaching on the correct physician posture during a patient encounter and current medical education hardly addressed this concern (45).

Patients themselves might have varying needs and may feel more comfortable in different settings, with no “one size fits all” formula (46).

In the Italian scenario, oncologists do not attend any curricular training in communication whatsoever (55). Only 1 study has been found that explored the impact of communication courses on the knowledge and attitudes of oncologists (47).

Outpatients examined by physicians who attended the communication training program displayed a higher decrease in state anxiety levels than outpatients examined by physicians from the control group.

We studied the doctor-patient first approach. A collection of several psychological studies on the “thin slicing” phenomenon leads to hypothesize that, at the first meeting, people get an idea of the other almost instantly.

When the patient opens the consultation room and looks at the doctor, he has already begun to form an (unconscious) opinion about him.

We should remember that while the doctor evaluates the patient also the patient is evaluating the doctor.

Relationship is a two way process.

The initial handshake normally expresses an intention to work together, to “be there” (but it should be avoided if there are suspicious cultural differentiate, if the patient is fragile, if he has pain, if he is infected or is not in the right state of mind).

We found that in the consultation room the doctor introduced himself in 85% and has shook hands with patient in 100%, then in the follow-up visits, he didn’t introduce himself but shook hands with patient in 86%.

This is a very high percentage because generally doctors do not often introduce himself to patients/caregiver nor shakes his hand during the first approach in the consultation room.

In NLP we use to say that the “first approach"" is one of the most important step for a good communication in fact, on entering the room it is always appropriate to extend a greeting to the patient. Greetings do not take long (15-20 seconds) and should be done before turning to the computer.

The pleasantries phase depends also on the patient's culture. In US the “greeting phase" is often considered unnecessary. In Italy, Middle East and Asia it is essential to any negotiation.

In the first examination visit this phase was present in 61%, while in the follow-up visits in 45%.

During a communicative exchange three levels of communication (words, voice and body language) implement a key role for the relationship success.

The interpersonal communication techniques suggest that when the words, voice and body language are “consistent"" the receiver will have confidence in what is communicated.

Till our body is our main “communicator" it is important to know that the control we have of ourselves “declines" from head to foot, and it is lower on the left side of the body and greater on the right (for right-handed).

A patient can says that he is comfortable, but he keeps one foot directed towards a possible escape route like a door; thus his verbal message is contradicted by his body position.

A doctor that says: “I'm interested in what you're saying" but has his feet, torso or pelvis oriented to the door proves to have “not consistent" with intentions that he is saying as when he says “to pay attention" while using his phone to write or speak.

We found that in 66% the doctor's pelvis was oriented to patient and his torso was forward in 54%.

These data are encouraging us because, depending on the stage of the interview, it is normal that doctors has his pelvis toward the patient or the upper body forward, it would be an “alarm bell" if the doctors had not had these attitudes body in less than 30% of the time of the visit.

Moreover, in 34% of the time, doctor's basin was in the PC's direction, this is due to the fact that a lot of “bureaucracy" affect “average time" of visits, but if the doctor shares the screen with the patient or "reads out" what he is writing makes the patient feel a participant of his case.

Crossed arms and legs are not always synonymous of closure. We found that in 45% doctors had crossed legs and crossed arms in 7% of cases. We can’t say that these data means a “negative assessment" because they need to be compared with the patient's posture. If the patient's legs or arms are crossed the communication is very effective (“mirroring" is a NLP's technique (48)), unfortunately this data on the observation of the patient-caregiver has not been surveyed.
Mirroring and matching are two NLP’s techniques used to gain rapport at the unconscious level. This is possible by becoming like the person with whom we need to make a connection. We can mirror or match one’s voice and posture, blinking and facial expression, words and gesturing, physiology and position.

Mirroring (and crossover mirroring) help in establishing a confidence climate which gives to the interlocutor the desire to say more, because he feel heard and acknowledged for what he really is. Matching is the communicator’s ability to send to his patient a message like: “I understand you because I’m like you”. When doctor match a patient, the patient will make the same movement, will have the same voice and use the same words.

Patient will have greater “willingness” to be led as much more has been matched by the doctor.

We found that patients not always like to look at the doctor eyes when they talk. Without going into the detail of what NLP calls “preferred representational system” (PRS) we have to know that it is only the “visual patient” that likes to looks you in the eyes and that will seat in front of you.

“Auditory patient” will prefer to hear the physician’s voice and will sit in ¼ (shear) often by standing to his side, while the “kinesthetic patient” prefers physical contact and often sit near the doctor, looking for a physical contact, touching the forearm, hand or shoulder to attract his attention.

Representational systems are the systems that we use to internally code and store our five senses data. The coded data is stored in the form of internal representations which build our internal maps or models of the world. All human beings are unique and each of us will tend to have a PRS that use to organize our experience and to construct the internal maps of reality and they are: Visual (things that we see); Auditory (things that we hear) and Kinesthetic (things that we feel).

The collected data about average time of oncolgical visits last 22 minutes for the first examination and 18” for follow-up visits. According to several studies, good communication does not seem to be “always” connected to the “available time”.

Studies have shown that a physician often interrupts a patient within the first 18 to 23 seconds of the encounter (49). Marvel (50) found that physicians who interrupted frequently didn’t discover the patient’s reason for the visit. On average, patients talk for 28 to 78 seconds when not interrupted (51).

By not interrupting, we are also telling the patient that we are listening and caring about what he is saying.

Despite the more or less time available in the clinical consultation Ley (16) found that 36% of patients do not remember the information given by their doctors about prognosis and treatment and 70% incorrectly assume the prescribes drugs.

A possible cause of these misunderstandings is the wrong information “exchange”.

We can say “exchange” because while the doctor speaks, patient continuously makes a sequence of valuable information through his body, through his voice and through what he asks.

A patient that uses a “visual” PRS will use to speak quickly and to place more emphasis on visually presented information (diagrams, notes, flow charts, drawings). An “auditory” tend to speak with a monotone voice (or very variable) and will prefer to receive schematic and brief information (like “bullet point”) will pay much attention to the doctor’s voice and he will have a medium flow of voice (or very variable).

The “kinesthetic” patient prefers to “touch” what it is said, generally he speaks slowly and with his palms upward and he musts “try on his skin” to understand a concept, the doctor will have a good relationship with him if he will make him “do” something physically, and touch him (a hand on his shoulder, arms, etc.).

Langewitz (51) investigated a sequential cohort of 1137 patients from the outpatient clinic of the department of internal medicine at the university hospital in Basle. The average patient visiting a doctor in the U.S. gets 22 seconds for his initial statement, then the doctor takes the lead (50). Mean spontaneous talking time was 92 seconds, and 78% of patients had finished their initial statement in two minutes. Seven patients talked for longer than five minutes.

Between 22” and 92” patients say 75% of extra symptoms.

It seems that the more patient speaks of his problems, the more come to his mind new relevant information.

If doctor stops him in the beginning (22”) he risks to lose a lot of important clinical information.

Finally, in our research we found that the doctor drew a diagram, design or notes in 45% of first examinations and 25% of the follow-up visits, it is a very low data if you consider that most of the patients are Visual and therefore prefer the view, the diagrams and drawings to recall information from the outside world. This is definitely an easily improvable point.

Conclusion

An effective communication allows to gather relevant quantity and quality information. This reduces the possibility of error and it allows doctor to leave the patient with the good feeling of being heard and considered as a person as well, not only as a subject with a disorder or a question that need to be resolved.

The biopsychosocial and emotional aspects of the interview are best accomplished when the physician moves his head, eyes, and torso toward the patient; removes his hands from the keyboard or mouse; pushes the monitor away; silences his mobile and gives the patient his undivided attention (23, 25, 52, 53).

But it is not always possible.

Practice implications

We suggest:
1) Get up and go toward the patient (when he enters the room);
2) During the first examination visits introduce yourself saying your first and last name;
3) Shake patient’s hand;
4) Hold the body and pelvis oriented towards the patient;
5) Give him frequent signs of attention, nodding, “mimm, okay, yeah”;
6) Notify the patient (in the bureaucratic phase of data acquisition) that you will write his data in your computer (if it is possible, you can turn the screen in half toward the patient);
7) At the end of the interview ask the patient to repeat the salient points (drug therapy or behavior that he has to implement at home).

An effective communication has a good impact on care’s quality provided by the hospital. It makes the patient feels assisted with care and professionalism, but above all, it makes the patient feels that he can trust his doctor and believe in what he recommends and prescribes (increasing the compliance and recommending to friends and relatives to care in the same facility where he was fine).

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