UNIT NO. 2

COMMUNICATION IN CLINICAL PRACTICE

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ABSTRACT

Communication in clinical practice has several modes – verbal, non-verbal, and written. Verbal communication requires attention to the components of sender, message, and receiver; transactional analysis; and lifespace analysis. Non-verbal communication tells of feelings and emotions that the patient is experiencing. Written communication helps the patient to remember the important information. One effective communication model in clinical practice suggests that we pay attention to the 4 Es – engage, empathise, educate, and enlist the patient – in the communication processes. Learning to be effective in communication has three components – cognitive input, modeling, and role play or video recording of one's consultation for critique and discussion. To reinforce learning, the doctor should be asked to reflect on what he has learned, what went well, and what might be done differently in the skill learning sessions.

INTRODUCTION

This unit of study covers:

- The importance of communicating well
- Understanding verbal communication, non-verbal, and written communication
- Common deficiencies in communication
- Towards an effective communication model in the consultation
- Pitfalls to avoid
- Learning points.

IMPORTANCE OF COMMUNICATING WELL

It is important to be able to communicate well (Maguire & Pitceathly, 2002):

- Doctors with good communication skills identify patients' problems more accurately
- Patients are more satisfied with the care of doctors who can communicate well and can better understand their problems, investigations, and treatment options
- Patients are more likely to adhere to treatment and to follow advice on behaviour change
- Patients' distress and their vulnerability to anxiety and depression are lessened
- Doctors with good communication skills have greater job satisfaction and experience less work stress.

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UNDERSTANDING VERBAL, NON-VERBAL AND WRITTEN COMMUNICATION

In clinical practice, communication is an admixture of spoken words (verbal communication) and non-verbal communication which is sometimes supplemented by written communication. The latter is useful as something for the patient to take home as a reminder of the communication that has taken place.

Verbal Communication

Writers on effective verbal communication have proposed models for analyzing the process. There are three aspects that we need to get them right: getting the components right, getting the transaction in the right mode, and also paying attention to the life-space of the patient.

Component Analysis

The component analysis model pays attention to factors in the speaker, message and listener that are barriers to communication.

Sender barriers:

(a) negative image - diffident, defensive, not looking at listener
(b) distracting behaviour - head scratching, twirling pencil
(c) aggressive behaviour - staring, mocking
(d) judgmental behaviour
(e) uncaring, insensitive.

Message barriers:

(a) information overload
(b) long words and long sentences in the message
(c) not being specific enough.

Receiver barriers:

(a) emotional distress
(b) judgmental reactions
(c) visual or hearing disability
(d) different frame of reference.

Transactional Analysis (TA)

Spoken communication may also be regarded as a transaction between personality states. The work of Eric Berne in the 1960s on the transactional model in communication pays attention to three personality states and the aim of analysis is to assess the appropriateness of personality states that are transacted. In TA theory, persons are said to normally exhibit three personality states regardless of their age:

Parent (P) - scolding tone, authoritarian attitude: uses words shouldn't, never, always
Adult (A) - logical: uses words "important that ...", "consider the ...."
Child (C) - demanding: use words "I want", "I can't", "I need".

Transactions that are adult-to-adult, child-to-parent, and parent-to-child are uncrossed. If the transactions are crossed as for example child-to-adult or parent-to-adult, then problems of communication will arise because the recipient will regard the communication as not appropriate.

Transaction analysis is useful in analysing communications that seek to elicit a particular action in the receiver. Some statements are more effective than others.

Example 1: There are different ways the doctor can tell the patient to stop smoking

Doctor: It is important that you give up smoking (adult) or
Doctor: You must stop smoking (parent) or
Doctor: I want you to stop smoking (child)

Which statement is the best for the doctor to use? It is likely that the adult mode will be best received. The others may trigger subconsciously a negative response in the patient. See Example 2.

Example 2: Different kinds of response

Doctor: It is important that you give up smoking (adult)
The patient's reply (amongst other things said) can be:

Patient: I can't (child), or
Patient: I know it is difficult but I'll try (adult), or
Patient: You should leave me to decide for myself (parent).

Life-Space Analysis

Each of us lives within a particular life-space or context. Our context is the world as we know it. There are six major areas that make up our world: (a) vocational, (b) family, (c) social, (d) spiritual, (e) physical, (f) financial. Communication efforts will fail unless the sender understands the life-space of the receiver. The ongoing self-appraisal and improvement will be the ability to recognise the context of these six areas in a patient and the appropriate response that will be necessary.

Take the vocational area for example. We will need to recognise what being a taxi-driver mean in terms of the demands of the job, the daily struggles that he goes through to be able to have the empathy and appropriate response when he complains of backache or headache. Is his presenting problem therefore physical, social or emotional?

Non-Verbal Communication

A study by Albert Mehrabian in the 1960s at the University of California, Los Angeles concluded that in communication:

- 7% of meaning is in the words that are spoken.
- 38% of meaning is paralinguistic (the way that the words are said).
- 55% of meaning is in facial expression.

Spoken communication in the clinical setting generally deals with facts. Feelings, emotions, values, wants and interest/ disinterest tend to be communicated non-verbally.

The Importance of Non-Verbal Communication

The importance of nonverbal communication are:

- From the non-verbal cues the doctor can read a lot about the patient's anxieties and concerns. The ability of the doctor to respond to these cues establishes a rapport with the patient because the patient feels that he or she is understood.
- Non-verbal communication may be intentional (e.g., a nod to indicate understanding), but is often unintentional. Cues to dissatisfaction, "yes" or "no" are often unintentionally displayed. Observing these cues can be a great help in knowing what the patient actually wants. Non-verbal cues are more reliable than spoken words.
- Non-verbal cues can also give away a person's disinterest. Patients can read such non-verbal cues and decide whether the doctor is interested in listening to what they have to say.

Classifying Non-Verbal Communication

Classifying the different categories of non-verbal communication allows us to understand the different components of non-verbal communication.

There are seven such categories, namely:

- Proxemics, e.g., personal space, seating arrangement at meetings, distance between individuals while in conversation, and time.
- Artifacts, e.g., clothing, make-up, eye glasses, jewellery.
- Kinesics (body language), e.g., hand gestures, body postures, facial expressions and eye movements, gait.
- Paralanguage, e.g., vocal pitch and emphasis, intonation, expressions such "uh huh", "well", "you know".
- Touch, e.g., handshake, skill at which physical examination is done.
- Environment, e.g., furniture, room decorations.
- Physical characteristics, e.g., state of health, body shape, skin colour, skin, deformities, characteristic body odours (diabetic ketosis, uraemia and alcohol consumption).

A brief description of each is given.

Proxemics

This is concerned with space, position and time.

- ***Space and position.*** People maintain certain distances during conversations. The way family members sit as a group can tell much about relationships amongst one another. A good consultation position is to sit on adjacent sides of a table. Sitting across the table puts a barrier between the doctor and the patient. Some may find it more emotionally comfortable to keep it that way.
- ***Time.*** The doctor may give the impression that he is very busy if he appears hurried, impatient, time-conscious and attending to many things at the same time. The patient may feel that he should not waste the doctor's time and go away dissatisfied. It is possible to project a different impression that the doctor has time through the use of non-verbal communication : listening to the unhurried

patient, speed and unhurried tone of speech, use pauses for the patient to reply without hurrying and not allowing interruptions, e.g., from the telephone.

Artifacts

Clothes bias positively or negatively the doctor-patient communication; being appropriately dressed is therefore important.

Kinesics (body language proper)

Kinesics tells us about people's level of interest, acceptance, agreement, satisfaction and feelings of anxiety, depression or fear.

- ***Face.*** The face is a carrier of emotions (e.g., anger, joy, happiness).
- ***Shoulders.*** They are raised if tensed; lowered if relaxed.
- ***Head position.*** Raised if showing openness, interest and control over situation; lowered if in doubt, defeated, in fear or insecure; tilted sideways if interested.
- ***Body posture.*** Upright posture indicates confidence, upright and backward leaning indicates defensive or reticent frame of mind.
- ***Hand gestures.*** Fear or uncertainty is expressed by hand-to-nose gesture. Hand over mouth indicates doubt of what is being said. Steepling (joining hands, with fingers extended and fingertips touching) indicates confidence and assurance in the comments being made.
- ***Folded arms.*** Folded arms are a nature position of comfort; however, they can also communicate messages of defensiveness, disagreement or insecurity.
- ***Legs.*** Sitting forward in the chair with feet placed in the "ready to run" position indicates disinterest.

Paralanguage

- ***Emphasis.*** The emphasis on different parts of the sentence conveys the meaning of the message. Thus, it is important to note not only what is said but how it is said.
- ***Rate of speaking.*** Fast speaking occurs in anger, joy or excitement; slow speaking occurs in sadness.
- ***Tone.*** A soft voice, low pitch and irregular pauses are some of the vocal characteristics associated with depression. Anger or irritation is also displayed through the tone of voice.
- ***Non-fluences.*** Slips of the tongue indicate anxiety, discomfort evoked by the situation; "er", "ah", "um" may indicate being unsure of what is being said.
- ***Pause.*** Being a good listener is rated very highly as an attribute. It appears that one of the factors involved is the ability to use pauses and hesitations.

Touch

Touch is the most important of the areas of non-verbal communication and especially so for the healing professions. The "laying of hands", "the healing touch" tell us of the value of touch as part of the consultation. Notwithstanding this, one has to guard against the risk of misinterpretation of intentions. It is important to get the patient's consent before one carries out a physical examination ("*Shall I examine you?*" or "*Please get on the couch, let's see what you have got*").

Written Communication

Written communication which includes sketches helps the patient to clarify ideas and aids comprehension. It also serves as a reminder on what has been said. A handout provides further information that the patient may find useful. Patient's written consent for operation is of course also needed for medico-legal purposes.

DEFICIENCIES IN COMMUNICATION

Known deficiencies in communication (Maguire & Pitcheathly, 20020) are the failure to:

- Elicit patients' reason for encounter and concerns.
- Obtain information about patients' perceptions of their problems or about the physical, emotional, and social impact of the problems.
- Provide information in the way that the patient understands and to check how well the patient has understood what he or she has been told.
- Seek out what information the patient wants to know.

The major underlying reason for these deficiencies is the doctor is reluctant to depart from the strictly medical model, and has not dealt with psychosocial issues, or adopt a more negotiating and partnership style. There may also be a reluctance also of inquiring about the social and emotional impact of patients' problems on the patient and family lest this unleashes distress that are difficult to handle for the uninitiated. Consequently, the response to emotional cues is to block further disclosure (Macquire & Pitcheathly, 2002) by:

- Offering advice and reassurance before the main problems have been identified.
- Explaining away distress as normal.
- Attending to physical aspects only.
- Switching the topic.
- "Jollying" patients along by asking the patient to look on the positive side of things.

TOWARDS AN EFFECTIVE COMMUNICATION MODEL IN THE CONSULTATION

Many models of effective communication in the consultation have been proposed and one of these is the 4E model developed by the Bayer Institute. The 4Es cover the four communication tasks to:

- Engage
- Empathise
- Educate
- Enlist.

The 4Es are preceded by the opening of the consultation of greeting the patient and putting him or her at ease. The ending of the 4Es is followed by the closing of the consultation.

Engage the patient

Use the first few minutes to build rapport with the patient. Use a pleasant consistent tone of voice. Be curious about the person as you are about his or her medical condition:

- New patient – "Before we begin, tell me something about yourself."
- Return patient – Mention something personal from the previous visit or enquire how things have been since the last visit.

Next, elicit the expectation or goals for the present encounter. Ask "What were you hoping we accomplish today?"

Get all the complaints that the patient has. Ask "It there anything else that you would like to tell me?"

The next step after going through the list of complaints and understanding their chronological order is to summarise the patient's agenda. List the issues. "I want to make certain I've got everything, that you have the symptoms of … and you are concerned about…"

There may be a need to negotiate the patient's agenda if there are several problems to be dealt with. Prioritise the problems with the patient. "Shall we deal with the headache that you have first, and leave the rash for the time being until we have sorted out the cause for the headache?"

Next comes the step of eliciting the patient's story. Use open questions first – "I am curious about …" Allow the patient to tell the story with minimal interruption. Acknowledge the story where appropriate – "That must have been uncomfortable." Use reflective listening – "I hear that you are worried whether this headache is due to something sinister…"

Empathise with the patient

Use empathy to show that you have some sense of how the patient is feeling – "The experiences you describe during your mother's illness must have been difficult for you." Use educated guesses too. Feedback to patients your intuitions about how they are feeling – "You say you are coping well, but I get the impression you are struggling with this treatment." Even if your guess is incorrect, it shows patients that you are trying to further your understanding of their problems.

Educate the patient

It is likely that the patient wants to find answers to the problem and what are the options to deal with the problem. Hence assume the following questions and answer them as a matter of course:

- What has happened (diagnosis)
- Why has it happened (etiology)
- What is the going to happen (prognosis
- What could be done to deal with the problem (options)
- Is there a particular option you would recommend and why.
- Will it hurt or harm – How much? How long?

Check understanding as you go along. "From what we have discussed today, is there any area that you would want me to go over again?" With complex illnesses or treatments, check if the patient would like additional information – e.g., a handout.

In discussing treatment options, check if the patients want to be involved in decisions. Patients who take part in decision making are more likely to adhere to treatment plans. Determine the patient's perspective before discussing lifestyle changes – for example, giving up smoking.

Enlist the patient

The successful management of the patient will often require the patient's motivation to provide self-care. This is particularly so in chronic medical conditions and lifestyle related conditions. You can help the patient by applying the following strategies:

- Keep regimen of treatment simple.
- Tailor to individual habits and routine.
- Get feedback from the patient.
- Write out the regimen for the patient.
- The benefits that will result in keeping to the regimen.

Communication in closing the consultation

The following communication steps are required in closing the consultation:

- Anticipate and forecast close of visit – "We will need to finish up soon, is there anything else that we should discuss before you go?"
- Summarise diagnosis, treatment, and prognosis.
- Review next steps – next visit, phone call, test results.
- Say good by and express hope.

LEARNING COMMUNICATION SKILLS

There are three steps in learning to improve one's communication skills:

- Cognitive input – notes such as these form the theoretical information and framework towards a more effective communication with patients.
- Modelling – watching positive and negative demonstrations help one to see how communication in various scenarios and problem situations are conducted. This can be video clips, and/or live demonstrations.
- Role plays and recorded consultations – these provide opportunities to practice communication skills. The discussion of such learning sessions needs to be sensitive and constructive. To reinforce learning, the doctor should be asked to reflect on what he has learned, what went well, and what might have been done differently.

PITFALLS TO AVOID

The following are not the only pitfalls. They are the common ones encountered:

- Avoid the use of blocking behaviour in response to emotional cues.
- Avoid the use of closed questions initially that elicit a yes or no answer from the patient; the strategy is to begin the communication with an open question – "Tell me more about your headache."
- Avoid interrupting the patient until he or she has finished telling the story of illness or experience
- Avoid the use of jargon or technical words but if there are no better words to substitute these then explain what the word used means.

REFERENCES

1. Bayer Institute for Healthcare Communication. Clinician-patient communication programme to enhance health outcomes, 2001.
2. Maguire P, Pitceathly C. Key communication skills and how to acquire them. BMJ 2002; 325:697-700.

LEARNING POINTS

- **Communication has several modes – verbal, non-verbal, and written**
- **Non-verbal communication tells of feelings and emotions that the patient is experiencing**
- **One effective communication model pays attention to the 4 Es – engage, empathise, educate, and enlist the patient – in the communication processes**
- **Learning to be effective in communication has three components – cognitive input, modeling, and role play or video recording of one's consultation for critique and discussion**
- **To reinforce learning, the doctor should be asked to reflect on what he has learned, what went well, and what might be done differently in the skill learning sessions.**