Module 01: Welcome to DocCom!
by Geoffrey H. Gordon, M.D.

© 2005-2014 by AACH, Drexel University College of Medicine and others - see copyright info for details

"DocCom" is a joint production of the American Academy on Communication in Healthcare and the Drexel University College of Medicine. It is made possible by a generous grant from the Arthur Vining Davis Foundations.

Credits:

Author: Geoffrey H. Gordon, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Clinician on camera: Geoffrey H. Gordon, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assistant Director: Dennis Novack M.D.

Version History:
3.0 - added HTML5 version (tablets)
2.0 - 7/1/09 (upgrade to DocCom V4)
1.0 - 6/27/05
Rationale

A growing body of evidence shows that interpersonal communication skills strongly impact crucial health care outcomes. Training to competency in communication skills is increasingly required for clinicians at all levels of training.

The medical interview is the most common procedure that clinicians will perform - numbering more than 150,000 scheduled interviews for a typical career, and additional countless telephone calls and unscheduled interviews with hospitalized patients and family members. In a busy practice, improving communication is often regarded as a luxury, and many clinicians believe that good communicators are “born not made.” In reality, communication skills must be learned, practiced, and maintained. (1-3) Key clinical outcomes related to communication skills include greater patient and clinician satisfaction, greater patient understanding and acceptance of treatment plans, reduced patient distress, and fewer lawsuits. (4-7) Interventions to improve clinician-patient communication can lead to improved biomedical outcomes such as better self-management of diabetes, reduced postoperative morbidity, and better coping and quality of life in cancer. (8-10)

One way that communication skills affect outcomes is by determining the accuracy and completeness of the data available to generate hypotheses about the disease and the patient. (11) Communication also forms the basis for a therapeutic alliance, based on mutual trust, respect, and understanding of each other’s ideas, feelings, and values. (12) The success of this alliance predicts patients’ understanding of their conditions, adherence with treatment plans, and relief of pain and distress.

The skills include identifying and removing barriers to communication (physical, psychological, social, cultural), surveying the patient’s concerns and negotiating a consensual agenda for the visit. (DocCom module 7) The patient’s uninterrupted opening statement will help you decide how actively you will need to guide the flow of information. Creating a shared agenda helps keep both of you “on track” during the encounter and rewards patients for taking an active role in their care. (14) Evidence shows that using these skills, and the skill of making explicit empathic and caring statements (DocCom module 6) saves time.(2,14-16)

Finding the right balance between patients’ narrative and clinicians’ diagnostic inquiry is a never-ending “dance.” Most interviews move back and forth between narrative and inquiry to create a common language and understanding of the problem. (17,18) In addition to being immensely satisfying, the dance establishes trust and respect and promotes willingness to share the tasks of care. (19) It also makes the processes of giving information (DocCom module 10), negotiating a plan of care (DocCom module 11), enlisting the patient’s active participation and planning follow-up more effective and efficient. The form and function of the dance are addressed more fully in the module on “Structure and content of the interview.” (DocCom module 5)

Questions for Reflection:

- What does the term “communication skills” mean to you?
- You have been communicating and practicing communicating all your life. What special skills can you imagine learning, and how will you learn them?
In thinking about an experience you have had with a clinician when you or a family member were a patient, how did the clinician’s communication skills affect your sense of trust, allay your concerns, help you understand your illness, engender hope? What specific skills did your clinician use to enhance or inhibit communication? Were you able to say all that you wanted? Why or why not?

How motivated are you to learn the skills that will make you more masterful in clinician-patient communication?

Key Principles:

- Effective communication requires a set of core skills that underlie every aspect of clinical care.
- Better communication skills produce better health care outcomes.
- Communication skills can be taught, learned, maintained, and enhanced.
- In order to improve your communication skills, you need motivation, self-awareness, a specific focus and self-care.

Learning goals:

At completion of this module, learners will be able to:

- Describe the importance of self-awareness in effective communication.
- Describe 7 essential elements of clinical communication.
- Describe 8 evidence-based outcomes linked to clinician communication.
- Describe 4 common deficiencies in clinician communication skills.
- Describe 4 features of effective teaching of communication skills.

INTRODUCTION

DocCom meets the needs of trainees, clinicians, and accrediting and licensing bodies for education and proficiency in healthcare communications.

The past few decades are marked by a growing attention to clinician interpersonal and communication skills. Clinicians are re-discovering that their patient relationships are a major source of personal and professional satisfaction. Patients are asserting their desire for better communication with their clinicians. Researchers are establishing links between clinician communication behaviors and vital health care outcomes. Some health care organizations are changing their policies and procedures in response to these changes. (20)

At the same time, medical educators have noted that students’ communication skills are eroded or “unlearned” during their training. (21) Most medical schools teach the basic skills, but many lack the resources, methods, or faculty training necessary for effective teaching in this domain. (22) In 1999, the Association of American Medical Colleges (AAMC) called for greater teaching of
communication skills (23), and in 2003 the Accreditation Council for Graduate Medical Education (ACGME) called for competency-based teaching and assessment, including “interpersonal and communication skills” as a core clinical competency required for successful completion of residency training. (24) The American Board of Medical Specialties (ABMS) adopted the same competencies for re-certification.

American Academy on Communication in Healthcare: DocCom

The American Academy on Communication in Healthcare (AACH) is an organization of clinicians and others interested in supporting and advancing education and research on communication, clinical relationships and related psychosocial skills.

The Academy’s courses integrate lectures and readings with hands-on, small-group skills practice, peer observation and feedback, and opportunities to reflect, discuss, and integrate these experiences into our personal and professional lives.

This DocCom program, developed by AACH with support from the Arthur Vining Davis Foundations and Drexel University College of Medicine, is designed to help learners and clinicians improve their communication skills. DocCom uses short didactic presentations and video demonstrations with commentary to illustrate important facts and skills. It also includes modules on self-awareness and self-care. Each module includes learning goals, key principles, questions for reflection, text and videos, and a behavior checklist. Learners can follow hyperlinks to references and resources. Web-based features enhance learners’ experience, including the ability to chat live with others around the country using this resource, threaded discussion groups, and more. The modules are authored by experienced and respected medical educators, many of them AACH members.

COMMUNICATION SKILLS AND THE STRUCTURE OF DocCom

Skills are specific behaviors or tasks than can be reproduced at will.

Clinical communication utilizes a set of skills defined from research, expert opinion, and consensus. Educators have organized the skills into conceptual models that aid recall, application, and assessment. Certifiers are also concerned with measuring skills and setting standards. This DocCom resource addresses five broad categories of communication skills:

1. **Basic principles** (5 modules)
2. **Essential elements** (7 modules),
3. **Advanced elements** (7 modules)
4. **Specific situations** (17 modules)
5. **Communicating with colleagues** (6 modules)

Basic Principles
The 5 Basic Principles modules emphasize the critical role of self-awareness and self-care in effective communication.

**Module 2** on “Integrating Self-Reflection and Self-Awareness” discusses monitoring the relationship in real time, adjusting communication and interpersonal skills as necessary.

*Click here to see a short video about the rationale for this module*

**Module 3** on “Therapeutic Aspects of Medical Encounters” explores use of the self as a therapeutic agent in routine visits.

*Click here to see a short video about the rationale for this module*

**Module 4** on “Balance and Self-Care” addresses ways to refresh and maintain self-awareness skills, and to balance personal and professional identities.

*Click here to see a short video about the rationale for this module*

**Module 5** gives an overview of skills that are relevant to accomplish the 3 essential functions of every interview, building a relationship, gathering information and patient education, and the interview’s seven “essential elements” (see below).

*Click here to see a short video about the rationale for this module*

Module 5 emphasizes that the flow of an interview may bear little resemblance to its final written structure. The authors note that integration of the so-called “doctor-centered” elements with the “patient-centered” elements of communication in the daily work of medical care is a challenge for all clinicians.

The skills of self-awareness and self-care explored in the initial 5 modules promote our ability to listen, understand, explain, and “be with” others with minimal interference from our assumptions, expectations, and biases. (26). For example:

- Awareness of your own emotions can be a useful diagnostic tool ([DocCom](#) modules 6, 13)

- Awareness of hidden assumptions (“hot buttons” and “blind spots”) can help you build respect and trust with patients from various backgrounds, beliefs, and behaviors ([DocCom](#) modules 15, 18, 19)

- Awareness of your strengths and weaknesses in a group setting can help you listen and respond more effectively with families and colleagues ([DocCom](#) modules 20, 38)

- Self-awareness also promotes interpersonal skills, or the effect of communication on another person.([DocCom](#) module 2) Interpersonal skills are inherently relational and process-oriented. Examples of interpersonal skills include demonstrating caring and curiosity about patients’ ideas and values, and use of multiple sensory channels including intuition. ([DocCom](#) module 14)

---

**Essential Elements**

The Kalamazoo Consensus Statement defined the essential elements of medical
In 1999, teachers, researchers, and evaluators from medical schools and professional organizations attended an invitational conference on communication teaching, assessment, and evaluation. A major topic was delineating a set of teachable and learnable essential elements in clinician-patient communication. The conference included architects and representatives of 5 current models of doctor-patient communication, so they reviewed these models, their evidence base, and their applications. Ultimately they identified 7 essential elements of 25.

1) Build the relationship (module 6)
   Click here to see Julian Bird giving the rationale for this module

2) Opening the discussion (module 7)
   Click here to see Ron Saizow giving the rationale for this module

3) Gathering information (module 8)
   Click here to see Beth Lown giving the rationale for this module

4) Understanding the patient’s perspective (module 9)
   Click here to see Beth Lown giving the rationale for this module

5) Sharing information (module 10)
   Click here to see Beth Lown giving the rationale for this module

6) Reaching agreement on problems and plans (module 11)
   Click here to see Beth Lown giving the rationale for this module
Since its publication in 2001, the “Essential Elements” paper from this group has been widely used and cited. The concepts and ideas represent the collaboration and consensus of individuals from a variety of backgrounds in medical education. They also provide tangible examples of evidence-based skills that help teach and assess communication competency in a variety of clinical settings.

**Advanced Elements**

The 7 **Advanced Elements** modules contain practical information and skills that build on related Essential Elements.

The Advanced Elements modules speak to common communication challenges that may require specific knowledge and the use of advanced adaptations of the **Essential Elements** skills in order to best serve patients.

For example, this section includes modules on “Non-Verbal Behavior” (**DocCom** module 14) and “Responding to Strong Emotions” (module 13), an extension of the skills discussed in the “Build a Relationship” module of the Essential Elements (module 6).

**“Non-Verbal Behavior” (module 14)**

Click [here](#) to see Cecile Carson giving the rationale for this module

**“Responding to Strong Emotions” (module 13)**

Click [here](#) to see Barry Egener giving the rationale for this module

This section also contains modules on sexual (module 18), spiritual (module 19) and cultural issues (module 15) in communication that help us extend ourselves beyond the skills discussed in the Essential Elements modules of “Gather Information” (module 8) and “Understand the Patient's Perspective.” (module 9)
This section concludes with modules on “Informed Decision Making” (module 17) and “Promoting Behavior Change and Adherence” (module 16).

These modules present ideas and skills that increase our ability to address the complex everyday challenges of behavior change, enlarging on the skills outlined in the “Share Information” (module 10) and “Reach Agreement” (module 11) modules of the Essential Elements.

Special Situations

This section of DocCom contains 17 modules describing communication skills for specific situations. These skills are used in addition to, rather than instead of, the Essential and Advanced Elements skills.

The modules begin with a developmental approach:
and proceed to changing specific behaviors

- Smoking Cessation (module 24)
- Diet/Exercise (module 25)

managing psychiatric and psychosocial disorders

- Anxiety/Panic Disorder (module 26)
- Depression (module 27)
- Domestic Violence (module 28)
- Alcoholism (module 29)
- Substance Abuse (module 29)
- Somatization (module 31)

and end of life care

- Advance Directives (module 32)
- Giving Bad News (module 33)
- Terminal Care (module 34)

The section ends with modules on Discussing Medical Error (module 35) and Terminating the Doctor-Patient Relationship (module 36).

---

**Communicating with Colleagues**

This section of **DocCom** contains 6 modules on communicating with other health care providers.

The modules include

- The Oral Presentation (see DocCom module 37)
- Communication within Health Care Teams (see module 38)
- Talking with Impaired Colleagues (see module 39)
- Principles of Teaching Medical Students and Residents (see module 40)
- Professionalism: Boundary Issues (see module 41)
- Effective Clinical Teaching (see module 42)

---

**COMMUNICATION SKILLS MATTER**

Evidence for the impact of communication skills on crucial clinical outcomes continues to grow.

The evidence that supports the urgency of consciously using skills discussed in DocCom is referenced in each module. The type and strength of the evidence varies with the specific skills and outcomes measured. Much of this evidence is based in three types of research: correlation (coded interview variables correlated with outcomes); observation (events or observations correlated with outcomes); and intervention (subjects receive an intervention and outcomes are measured). For example, patient satisfaction with a visit correlates with clinician information-giving. (27) Clinicians with fewer malpractice suits were more likely to ask their patients’ opinions...
and to check their understanding of the treatment plan. (7) Patients of clinicians with 8 hours of training in emotion-handling skills reported reduction in emotional distress 6 months later. (2) The evidence linking communication skills to outcomes is summarized in a number of review articles and textbooks. (28-30)

**Patient outcomes** found to correlate with **good** clinician communication skills (and representative references):

1) Greater satisfaction with the encounter (27)
2) Improved psychological distress and coping (10)
3) Improved physical symptoms (6)
4) Greater recall and adherence (31)
5) Positive health behavior change (33)
6) Improved biologic markers (in some diseases) (8,33)
7) Reduced length of hospital stay (9)

**Patient outcomes** found to correlate with **poorer** clinician communication skills:

1) Greater disenrollment from care (34)
2) More malpractice suits (7,35)

**Clinician outcomes** found to correlate with **good** clinician communication skills:

1) More information available for treatment planning (36)
2) Fewer late arising concerns, such as “Oh by the way” items at end of visit (15)
3) Greater satisfaction with the encounter (5)
4) Greater comfort discussing sensitive issues (37)

---

**DEFICIENCIES IN CLINICIAN PERFORMANCE**

Good communication doesn’t just happen. Experience alone is a poor teacher, unless it is coupled with observation and coaching with feedback.

Communication deficiencies abound in practice. The major ones are listed below, with relevant references:

1. We interrupt patients in the earliest phases of the encounter. (16,38)
2. We fail to identify and prioritize patient concerns. (16,39)
3. We miss opportunities to understand and acknowledge patients’ ideas and feelings. (37,41)
4. We fail to understand the importance of culture and ethnicity in health care. (41)
5. We do not give bad news concisely and compassionately. (42)
6. We minimize patients’ roles in their care. (43,44)
7. We underestimate patients’ health literacy. (45)
8. We don’t negotiate differences well with patients. (46,47)
9. We fail to obtain adequate informed consent. (48)

---

**CAN COMMUNICATION SKILLS BE TAUGHT AND LEARNED?**

Yes, communication skills can be taught and learned with appropriate teaching methods, and maintained with periodic reinforcement.
Maguire’s landmark study of medical students demonstrated that communication skills training with video feedback led to stronger listening, clarification, and inquiry skills five years later. (49) More recently the Macy Initiative in Health Communications showed improvement in students’ overall competence in communication, as well as skills in relationship-building, patient assessment, negotiation, and shared decision-making. (1,50) Postgraduate communication skills training is less well studied. (51-59) Continuing education programs in communication skills demonstrate an impact on clinician behavior. (2,3,60-62). The evidence that clinician communication skills training impacts behavior (63) and outcomes (64) was recently reviewed, and the evidence was used to develop comprehensive, consensus-based approach to teaching. (65) Two articles and a book chapter on assessing communication skills have also been published. (66-68) Many of the issues presented in DocCom are also discussed in a short, concise text, the Field Guide to the Difficult Patient Encounter, which has received positive reviews in medical journals. (69)

Additional teaching and assessment tools can be found in the Outcomes Project area of the ACGME website at www.acgme.org.

### Effective teaching methods

Evidence demonstrates that specific teaching strategies improve communication skills.

Effective teaching methods include the following:

1. Exploration with learners of the evidence base and rationale for using particular skills.
2. Presentation of a cogent conceptual model to help learners understand, organize, recall, and apply skills.
3. Hands-on, small group practice with observation and feedback.
4. Opportunities to reflect on experience as a clinician and learner.
5. Periodic reinforcement and deepening of skills over time.

A description or demonstration of skills is needed to give students a sense of what the skill should “look like.” Hands-on practice in small groups with observation, feedback, and repetition after feedback are important next steps. Feedback is more effective when coupled with videotape review or “debriefing” with the patient. With a little experience, learners can begin setting and pursuing individual learning goals based on their interests, feedback, or predetermined curricular goals. Reflection is best done in groups, where faculty can model and facilitate listening, explaining, and empathy skills. Reflection can be deepened with personal journaling. These activities promote learning skills of self-reflection and self-awareness.

A variety of effective teaching methods exist (e.g., role play, video review, simulated patients) but none of these has consistently been shown to be superior to others. The proper timing, and “dose-response” properties of this teaching are unclear but involve several initial sessions followed by regular revisiting and deepening of skills. A number of excellent texts on communication skills are now available for a variety of audiences.

### Becoming a Lifelong Learner

Medical practice is changing rapidly, and the content and process of communication is changing with it.

Communication, like any medical procedure, requires constant revision and updating of skills. Information technology, electronic communication, collegial and interdisciplinary communication, patient safety/error disclosure, and defining the notion of professionalism and its relationship to
communication are only a few of the areas on the communication skills horizon. Fundamental skills to communicate compassion and empathy have a timeless and cross-cultural application, and nevertheless must be fine-tuned to adjust to new developments in technology (organ transplants or HIV or chemotherapy treatments) and changing values in society (such as death with dignity, HIPPA regulations).

Health care organizations, malpractice carriers, and professional societies already offer or endorse communication skills training for practicing clinicians. Professional societies publish articles on communication and the clinician-patient relationship in their journals, and offer communication skills training during national meetings or special sessions. Finally, organizations such as American Academy on Clinician and Patient, the Society for Teachers of Family Medicine, and others provide opportunities for regular enhancement of communication and interpersonal skills. The network of clinicians and educators committed to improving communication skills and the clinician-patient relationship, for themselves personally and for the medical profession is growing.

**CONCLUSION**

The evidence for the positive impact of excellent communication skills on key clinical outcomes continues to grow.

However, improving the communications skills set is often discounted as an unaffordable extra ("our priority must be to focus on learning more about diseases and how we can treat them"), oversimplified as a personality trait ("good bedside manner") or dismissed as etiquette ("being nice"). Communication skills can be taught, learned and retained with appropriate educational methods. Educators emphasize that this is a challenging topic to teach and learn, because it requires us to examine our assumptions, feelings, and values regarding our selves, our patients, and our work. We believe you will learn much from the faculty who have contributed to DocCom, and will discover new freedom of expression, levels of meaning, satisfaction and enjoyment in your clinical work as you master the many skills of clinician-patient communication.

**Best of luck!**

**LITERATURE REFERENCES**

14. Branch WT, Malik TK. Using 'windows of opportunities' in brief interviews to understand patients' concerns. JAMA 1993;269:1667-68
33. Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of clinician-patient interaction on
40. Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. JAMA 1997;277:678-82
61. Levinson W, Roter D. The effects of two continuing medical education programs on


loading..

Loading Video...

Dennis H. Novack, MD introduces

Module 02: Mindfulness and Reflection in Clinical Training and Practice

by Ronald M. Epstein, MD - production credits

© 2005-2014 by AACH, Drexel University College of Medicine and others - see copyright info for details

"DocCom" is a joint production of the American Academy on Communication in Healthcare and the Drexel University College of Medicine. It is made possible by a generous grant from the Arthur Vining Davis Foundations.

Module 02 Credits:

Author: Ronald M. Epstein, MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Clinician on camera: Dennis Novack M.D.
Video Director and Producer: Christof Daetwyler M.D.
Rationale

This module examines specific communication skills that promote mindful awareness, a key to effective clinical practice.

Mindfulness can also be applied to the acquisition of skills and knowledge, cultivation of caring and healing attitudes, and facing the anxiety of uncertainty.

Questions for Reflection:

1. How do others perceive you? What is it like to be with you? What impression do you leave after meeting someone for the first time?

2. When you are alone, what do you tend to notice about yourself? What do you tend to notice about others? What tends to escape your awareness? When you are with others, how do you listen? Do you often judge people?

3. Do you listen to others' underlying commitments, their hopes, their caring and generosity? How do you express compassion? What happens when you are tired, multitasking, overwhelmed or distracted?

4. Think about the most recent day you spent seeing patients (go to next question if you are not in a position to see patients), and identify a patient that made a strong impression on you. Perhaps you felt anxiety, concern, anger or sadness. Did the situation pique your curiosity? Or did you just want to avoid it? What did you notice about your reaction? Was it a habitual reaction? Was it an intentional and attentive response? How do you think that reaction may have influenced the way you communicated with the patient? Your medical decisions? The likelihood that the patient would return to see you?

5. If you have not had clinical experience, consider a kind of person who might trigger strong responses in you. Perhaps they might remind you of friends or family members, or even yourself. Or perhaps they are people unlike any whom you have previously met. How do you think that your reaction might influence your communication with patients who resemble in some way that person? Your medical decisions? Your interest or commitment to caring for patients who resemble that person in some way?

6. Think of recent learning experiences related to communication and relationship, and identify one that stands out in your memory. How do you think that response might influence the way you continue to learn about communication skills and clinician-patient relationships? Your relationship with instructors and mentors? Your relationship with patients who might help you learn as they interact and respond to you?

Key Principles:
Fundamental qualities of mindful practitioners are the following: attentive observation, critical curiosity, beginner’s mind and presence

Unanticipated events will fill your work days

Complex communications with patients and colleagues require more deliberation than routine clinical acts

Your self-awareness will be a key to your effective clinical care

You need practice paying attention to your own reactions and attitudes to be fully present for patients

Failing to examine your communication behaviors will delude you about your competence at clinical communication

You can avoid important mistakes through remaining mindful of how fatigue, emotional factors and avoidance affect your communication

---

**Learning goals:**

At the completion of this module, you will be able to:

- Describe how self-awareness improves clinical practice
- Describe how mindfulness limits mistakes
- Describe why experience seldom builds competence
- Describe fundamental qualities of mindful practitioners
- Cite 4 "reflective questions" that lead to mindfulness
- Describe why mindfulness and self-awareness are essential to improving professionalism
- Discuss with a colleague how you might practice becoming more mindful and self-aware, and consider the pros and cons of starting such a practice

---

**INTRODUCTION**

This module examines specific communication skills that promote mindful awareness, a key to effective clinical practice. Mindfulness can also be applied to the acquisition of skills and knowledge, cultivation of caring and healing attitudes, and facing the anxiety of uncertainty.

In this introduction section, you will find the following:

- **POEM: The Guest House**
  This being human is a guest house...
**Self-awareness is a key to effective medical practice**

Mindfulness means focusing your attention on your own thoughts and feelings in the moment.

**Clinicians are vulnerable to errors in communication due to lack of self-awareness**

Complex communications with patients and colleagues require more deliberation than routine clinical acts.

**The role of the unexpected in challenging clinicians to be more self-aware**

Unanticipated events pack the work days of medical professionals.

---

**“Being Human is a Guest House”**

Jelalludin Rumi (1207-1273) (1)

The Guest House

This being human is a guest house. Every morning a new arrival.

A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor.

Welcome and entertain them all! Even if they’re a crowd of sorrows, who violently sweep your house empty of its furniture, still, treat each guest honorably. He may be clearing you out for some new delight.

The dark thought, the same, the malice, meet them at the door laughing, and invite them in.

Be grateful for whoever comes, because each has been sent as a guide from beyond.

---

**Self-awareness is a key to effective medical practice**

Mindfulness means focusing your attention on your own thoughts and feelings in the moment. Self-awareness is knowing your gifts, areas for improvement, assumptions, prejudices and biases; toward people generally, toward patients, toward cognition, emotions, spirit and intuition in general, and toward these elements as they affect your professional work.

Self-awareness is a key to effective medical practice. (2) Just as pianists must be attentive and aware of each small hand movement to ensure accuracy and efficiency, effective clinicians must self-monitor the affect, tone of voice, choice of words, timing and emotional reactivity that they bring to each encounter. To avoid errors in diagnosis, we as clinicians must be aware of our own biases and tendencies towards premature closure. Also, in order to be fully present for patients, clinicians should work towards emotional health and balance in their lives. We believe that self
awareness, personal growth and well being should be specifically addressed in medical training. We have appended specific goals and objectives for this learning, as well as useful questions for reflection, that can lead to greater self awareness in relation to your patient care (see Appendix 1 and Appendix 2).

While the importance of self-awareness may seem obvious, achieving self-awareness is not straightforward. This chapter is about training for mindfulness – the qualities of attentive observation, critical curiosity, beginner's mind and presence that make possible the use of self-awareness to influence clinical practice (3,4).

**Clinicians are vulnerable to errors in communication due to lack of self-awareness**

Complex communications with patients and colleagues require more deliberation than routine clinical acts.

Will Miller characterized clinical practice as consisting of routines, dramas and ceremonies.(5) Routine clinical acts require little thought or psychological investment, dramatic situations require action in the moment, and ceremonies are ritualized and symbolic acts that require presence. Similarly, medical decisions are often made on the basis of pattern-recognition, on the evocation of complex remembered patterns of disease, and less commonly, through conscious deliberation. Some have argued for conscious deliberation of all medical decisions, but this is hardly practical. Unfortunately, automaticity brings the risk of unconscious incorporation of assumptions that may not be true, and emotional reactivity may override good judgment.(6) Communication with an individual patient at a specific moment about a particular problem may appear routine or ceremonial, but requires us to be self-aware and attentive to unexpected twists, concerns or new information.

**The role of the unexpected in challenging clinicians to be more self-aware**

Unanticipated events pack the work days of medical professionals.

In contrast to technicians, professionals not only follow protocols, but more importantly, learn how to individualize care, deal with unfamiliar and unanticipated situations, and make decisions with inadequate data, time or support. The “uninvited guests” described in Rumi’s poem are familiar to most of us: situations that involve ambiguity and uncertainty, situations in which there are conflicts between the needs of patients and clinicians, and situations characterized by strong emotions -- the patient's and our own. Technical errors, contradictory evidence and recommendations, and unanticipated complications challenge us on a daily basis. Recognition that our own knowledge is impermanent, that our sense of competence is fragile, and that control over a situation is illusory can be unsettling to even very experienced clinicians.

**MINDFULNESS, MINDLESSNESS AND DELUSION**

Mindfulness is “paying attention, on purpose, to one's own mental and physical processes during everyday tasks, so as to act with clarity and insight.” Delusion is the tendency of the mind to seek premature closure and to confuse our view of things with the way things are.
In response to difficult communications with patients and their families, clinicians respond with varying degrees of mindfulness and delusion. Mindfulness is a state of being that permits insight. Insight, in turn, makes correct action and compassion possible. Mindfulness “leads the mind back from theories, attitudes and abstractions to the experience itself.” Mindfulness is the study of subjective experience from the inside out. This subjective experience can include emotions, communication, ethical dilemmas, and procedural techniques. Mindfulness refers to a state of mind during everyday work, rather than analysis of our actions after the fact.

The absence of mindfulness is mindlessness and delusion. Mindless forgetting, insensitivity or haste can result from fatigue, emotional overload or overwork, and might be thought of as a manifestation of distractibility. Delusion, on the other hand, is a more clinically insidious phenomenon. It is “the tendency of the mind to seek premature closure...that quality of mind that imposes a definition on things and then mistakes the definition for the actual experience”(7). A common example of delusion would be looking at a prior diagnosis rather than the patient’s current situation in order to make a clinical decision – in communication and in diagnostic thinking, the patient is not “allowed” to have experienced change. Another example would be the inability to adopt a new perspective and rethink an initial impression of another person.

A case example of the lack of mindfulness causing an unfavorable outcome

A tired resident admitted a 50-year old man recently diagnosed with bladder cancer. In the emergency room, the patient was noted to have scanty urination, and was assumed to have been dehydrated. When IV fluids failed to increase the patient’s urinary output, the IV rate was increased. Because the diagnosis seemed so straightforward, the resident did not think to check the patient’s status. Several hours later, the patient, now in severe pain, was assumed by the nurse to be over-reacting. The following morning, another resident elicited a history of recent catheterization for urinary obstruction after bladder surgery. At that point, the possibility of urinary outflow obstruction entered the minds of those caring for him. His pain was now considered justifiable and the patient was offered analgesia and insertion of a Foley catheter. After two liters of urine drained, the patient experienced relief of his pain.

Lack of mindfulness is common, although not necessarily as dramatic as the previous example. Poor information gathering can be the result of a mind closed by paying more attention to a presumed diagnosis to the clinical state of the patient. Low-level decision rules (6) can result in premature closure. In contrast, the misdiagnosis could have been questioned earlier by adopting an attitude of attentiveness, curiosity, openness and doubt. As in this situation, mindfulness and delusion lead to poor judgment – by assuming things about patients that may not be true, or not acknowledging the limits of your information or knowledge. One of the most difficult qualities to teach and assess is presence – the sense of “being there”, undistracted and in tune with the patient and his or her needs. These can all be affected by situational factors such as fatigue; each of us has a threshold beyond which judgment begins to suffer. We can learn techniques, such as those described below, for recognizing when our own cognitive and emotional processing are not optimal, and making appropriate adjustments to avoid miscommunications and errors.

Cognitive psychology of mindfulness and communication

Competent practitioners use both “tacit” knowledge and “explicit” knowledge. Tacit knowledge is hard to express, and derives from experience. Communication behaviors develop from a
lifetime’s experience, but that experience is seldom carefully examined, and frequently produces “delusions.”

The idea of mindfulness is based in cognitive psychology, which describes two types of knowledge necessary to be clinically competent -- tacit knowledge and explicit knowledge. Tacit knowledge is what one knows but finds difficult to express. An example is how to ride a bicycle, or in medical contexts, how to recognize that a person is sick. Some educators and philosophers suggest that tacit knowledge is the core of professional competence. Explicit knowledge is what can be easily explained, perhaps the differential diagnosis of a cough in a 70-year old smoker. Communication skills are usually tacit; that is, clinicians rarely think in the moment, “I have just used an open-ended question.”

Tacit knowledge depends on experience, but experience does not necessarily build competence. Repeated mistakes may constitute experience, and lead to unexamined errors in tacit knowledge, which we call “delusion”. Tacit assumptions may be unveiled as delusions and come to explicit awareness when a patient responds in an unexpected manner. For example, a student said, “I understand” in an attempt to be empathic, and was taken aback when the patient replied, “You couldn’t possibly understand unless you had what I have”.

Delusion can take other forms as well. For example, when asked about their communication behaviors, clinicians commonly believe they “regularly employ” certain skills, but when interviews are directly observed, their use of these skills is frequently not confirmed. We may believe that we give patients choices and solicit patients’ questions but observation shows otherwise. One way to counter such assumptions is to video-record consultations and review them later. Another way is to cultivate the ability to recall exactly what was said rather than sustaining a delusion of what “must have” taken place. Finally, medical practice frequently involves multi-tasking and even though it seems efficient, decreased attentiveness to the individual tasks often results in ignoring what would otherwise be obvious.

## Mindfulness and clinical errors

Becoming more mindful of how fatigue, emotional factors and avoidance affect communication may eliminate important mistakes.

At 3am a clinician working the night shift in the emergency department encounters an adolescent female patient who complains of lower abdominal pain. She initially denies that anything happened that might have caused the pain.

The clinician is trained in taking a sexual history, knows about the epidemiology of sexual and physical abuse, and has cared for victims of rape. At 3pm, encountering the same patient, this clinician would have inquired further – were any drugs or alcohol taken? Are you sure no one has tried to hurt you? You seem nervous – could you tell me if that is true? Would you prefer to talk with a female doctor? But, at 3am, those questions were not asked. The clinician reassures herself and the patient that this is a case of gastroenteritis or irritable bowel, and misses an important opportunity to identify sexual abuse and prevent future episodes.

The “lesion” in this interaction was not lack of knowledge or experience on the part of the clinician. Rather, it was a context-driven tendency toward premature closure – perhaps due to fatigue, perhaps because the clinician imagined the increased emotional energy, forms to be filled out and telephone calls required should a history of sexual abuse or rape be elicited. The “cognitive alibi” – that the patient has symptoms of a gastrointestinal disorder – seemed sufficient to justify not inquiring further. Now, imagine what would have happened if the clinician had been more mindful – if she had ability to recognize her tendency towards ignoring certain aspects of the patient’s history when tired, her inability to question her own thinking, her need to distance herself emotionally and her hasty decision-making. Perhaps a more mindful response to a complex
situation would have resulted in a better outcome.

HABITS OF MINDFUL PRACTITIONERS

Fundamental qualities of mindful practitioners are attentive observation, critical curiosity, beginner’s mind and presence.

The goal of mindfulness – and its four components – is to promote effective communication, wise decisions, and caring attitudes. Mindfulness includes awareness of the body, thoughts, emotions and sensations, and attention to our own level of mental alertness and restlessness.

This section is about:

- **Attentive observation**
  Attentive observation refers to the capacity to observe our own behavior while simultaneously being attentive to the patient – “observing the observer while observing the observed”.

- **Critical curiosity**
  Critical curiosity characterizes a mindful clinician’s response to the unexpected.

- **Beginner’s mind**
  “Beginner’s mind” means being willing and able to see a familiar situation with new eyes, setting aside biases, categorizations and pre-conceived ideas.

- **Presence**
  “Presence” involves being there, physically, cognitively and emotionally and a single-minded attitude toward healing and care.

Attentive observation

Attentive observation refers to the capacity to observe our own behavior while simultaneously being attentive to the patient – “observing the observer while observing the observed”.

Attentiveness involves both focus on the task at hand and also the capacity to see or hear things that are not in your direct focus, nor what you might be expecting to see or hear. By welcoming the unexpected, the attentive practitioner is able to examine data that might otherwise have been ignored. Attentiveness can be encouraged by example, trained using videotape review, and promoted by reflective questioning. One can also be attentive to one’s own state of mind. Recognizing that judgment may be impaired by fatigue or strong emotions (that may have nothing directly to do with the patient) is the first step in avoiding errors due to misperceptions or unclear thinking.

Critical curiosity

Critical curiosity characterizes a mindful clinician’s response to the unexpected.
Listening for the unexpected involves the ability to find surprise in the ordinary actions of daily work, and to listen to yourself and others without naming what is heard until it has been understood. In practice critical curiosity translates into avoiding premature closure. Rather than ignoring disconfirming or upsetting data, mindful clinicians engage in a disciplined further questioning or listening to the patient, and questioning their own judgment. Critically curious clinicians tolerate and learn from errors. Critical curiosity is not the seemingly undisciplined curiosity of a young child, and retains the capacity for filtering and judgment. Mindful clinicians are constantly vigilant for disconfirming evidence, and hesitate to assume that all relevant data have been elicited and processed.

“Beginner’s mind”

“Beginner’s mind” means being willing and able to see a familiar situation with new eyes, setting aside biases, categorizations and pre-conceived ideas.

The goal of medical education is to acquire expertise, but expertise has its dangers. As clinicians develop a taxonomy of illness and suffering, and categories of experience-based treatment protocols, they can lose the perspective that a newcomer might bring, an important element of mindfulness. The educator John Dewey called this perspective “cultivated naiveté” – or the capacity to adopt a “beginner’s mind”. In the case of the patient with urinary obstruction, those caring for the patient were not able to disentangle their image of the patient from the patient’s actual experience. By placing the patient in a category (“dehydrated patient”), they were unable to ask about, perceive or respond to symptoms that were obvious clues.

“Presence”

“Presence” involves being there, physically, cognitively and emotionally and a single-minded attitude toward healing and care.

Clinicians with presence are those who have the ability to lower reactivity and not be distracted by anxiety, in order to focus on the task and the patient rather than their own assumptions, needs and formulations. Presence includes patience, personal involvement and caring. Presence is required for the expression of compassion, because without it, attempts to be compassionate may be misdirected and inadequately address the patient’s needs.

BECOMING MINDFUL

You can become mindful, if you learn the characteristic behaviors of mindfulness and attend to developing and maintaining these skills and qualities in your work.

The qualities are listed below and examined in detail in the following paragraphs:

- **Priming**
  “Priming” means that clinicians have developed the expectation that they will be able to
report their own mental processes.

- **Being available**
  Being available means developing an openness to experience, learning to expect the unexpected, avoiding judging experiences as “good” or “bad”.

- **Reflective questions**
  Reflective questions that invite doubt disrupt habitual patterns of thought and behavior to allow a familiar situation to be seen in a new way, and to discover the uniqueness that is present.

- **Active engagement**
  Professional education should include frequent sustained contact between teacher and learner, observing the learners’ active engagement in thinking, skill development and personal awareness.

- **Role modeling and thinking out loud**
  Faculty members who model "thinking out loud" thus emphasize that professional medical practice requires the constant effort of recognizing and correcting for errors, rather than a linear pursuit of protocol.

- **Practice**
  “Practice” is disciplined repetition in controlled settings. “Practiced behaviors” become skills that require less effort to use daily

- **Self-monitoring**
  Self-monitoring refers to being aware of any disparity between intention and action, and between the imagined effect and the effect produced.

- **Assessment and confirmation**
  We suggest that mindfulness be one criterion for assessment of trainees.

---

**Priming**

“Priming” means that clinicians have developed the expectation that they will be able to report their own mental processes.

For example, a primed student and resident can report not only their clinical findings, but also their own thoughts and feelings during the visit. They can observe what they do to prepare themselves for each encounter. Do they stop for a moment? Do they complete the previous patient's chart? Do they develop a mental list of tasks? Do they take a deep breath? An early reflective question (“How might your prior clinical experience affect your decision-making in this case?”) might help set the stage for mindful inquiry. Other priming activities take place outside of the clinical setting. Reading poetry, for example, can invite an intense focus on the present moment. (9)

---

**Being available**

Being available means developing an openness to experience, to learn to expect the unexpected, avoiding judging experiences as “good” or “bad”.

Being available means quiet moments within the chaotic health care and clinical educational
environments. Training programs can use formats such as "reflection groups" to discuss clinical situations that raised difficulties for participants,\(^{(10,11)}\) "Balint groups" that explore strong emotional reactions that affect clinical care,\(^{(12)}\) and "family of origin groups" that explore trainees' experience of their families' values and their cultural norms in order to understand their positive and negative reactions to patients.\(^{(13,14)}\) Other formats that help the learner focus on the present include videotape reviews that remind practitioners of their emotions and biases, and provides space to examine them. Keeping a journal, meditation, and exercise are individual means to this end. However valuable these educational experiences are in themselves, their value is in preparing the learner to be present and available in real clinical situations. Clinical preceptors can model the presence and attentive availability that facilitates patient encounters.

### Reflective questions

Reflective questions are designed to help clinicians doubt their initial impressions, disrupt habitual patterns of thought and behavior, see a familiar situation in a new way and discover the uniqueness of each situation.

Reflective questions are designed not to edify, but rather to invite doubt and ambiguity. Asking reflective questions helps clinicians to identify opportunities for learning, seize them, and discover their own answers. For example, data gathering is commonly conditioned by the expected diagnosis. A resident might expect that a fatigued patient has a viral syndrome, and "forget" to ask about sleep, moods or feelings that might suggest that the fatigue derives from depression. Asking yourself, "What am I assuming about this patient that might not be true?" can provoke curiosity in an open-ended way, and improve diagnostic thinking. The answer may not be as important as the process of inquiry - in fact, many reflective questions have no answers.

Faculty members can help students internalize a habit of self-questioning that will improve the trainee's ability to listen and observe. Teachers should ask, "What did you observe?" "In what ways were you surprised?", "How did you respond to the feeling of surprise", "What interfered with your observations?" and also, "If there were relevant data that you ignored, what might they be?"

The teaching of clinical ethics benefits from using reflective questions. A preceptor can comment on "tacit ethics of the moment" as reflected in small gestures that often go unnoticed in daily practice. They can ask learners to note those small moral acts, such as how nods of the head convey interest or not, or how the clinician acknowledges an error to a patient

### Table of reflective questions

- “How might my prior experiences affect my actions with this patient?”
- “What am I assuming about this patient that might not be true?”
- “What surprised me about this patient?” “How did I respond?”
- “What interfered with my ability to observe, be attentive or be respectful with this patient?”
- “How could I be more present with and available to this patient?”
- “Were there any points at which I wanted to end the visit prematurely?”
- “If there were relevant data that I ignored, what might they be?”
- “What would a trusted peer say about the way I managed this situation?”
- “Were there any points at which I felt judgmental about the patient – in a positive or negative way?”
Active engagement

Professional education should include frequent sustained contact between teacher and learner, observing the learners’ active engagement in thinking, skill development and personal awareness.

Medical education is too often structured as if the most difficult matters are learned without critique or mentoring. In his essay, "What if they taught musicians the way that medical students are trained?" Engel (15) describes an imaginary scenario in which music students would never be observed actually playing their instruments, and would report what they had done. We can laugh at this absurdity, but need to examine closely what we do in medical education. The making of musicians requires that technique be made sufficiently automatic so that they do not have to think about every muscle movement, but can maintain enough subsidiary awareness to recognize when technique needs more focused attention. Similarly, they bring awareness to the harmonic structure at key transitional moments, but let it inform the interpretation in a more tacit way at other times. Competent clinicians know how to actively engage with patients while balancing personal awareness, skill use and cognitive reasoning, just as musicians have the awareness, technique and knowledge to be musically expressive and to simultaneously listen from the perspective of the audience.

Role modeling and thinking out loud

Faculty members who model "thinking out loud" thus emphasize that professional medical practice requires the constant effort of recognizing and correcting for errors, rather than a linear pursuit of protocol.

Thinking out loud can help convert tacit knowledge to explicit, and reveal paradoxes and inconsistencies between intended and real effects of our actions. This can occur while teaching about communication, clinical reasoning or even technical skills. For example, surgical training now includes virtual reality training to help residents "think out loud" while performing simulated procedures that involve fine manipulations of laparoscopic instruments. A similar process can provide in-the-moment feedback on communication behaviors using videotape or live observation.

Practice

“Practice” is disciplined repetition in controlled settings. “Practiced behaviors” become skills that require less effort to use daily.

Among performing artists, a common saying is, "in discipline is freedom." Practice requires an object, real or imagined, external or internal. The object of meditation is one's own thought process, of music it is sound and the audience, and of medicine it is the patient and the learner. Availability, active engagement, listening deeply (especially to those things that we’d rather not hear), generosity and "beginner's mind" can be practiced. "Unexpecting" is an aspect of practice that refers to training ourselves to recognize our expectations, and then imagine another outcome.

Curiosity can be practiced. For example, try spending 15 minutes simply recording in writing the names of all red things that you see. Even such a simple exercise can bring awareness to one’s tendency to become excited, bored, curious or annoyed when presented with a routine task. Participants usually report suddenly categorizing the world into red things, which are of interest, and non-red things, which are ignored. Then they wonder about those categories asking, "How red
does something have to be to be considered 'red'?" A parallel situation would be for clinicians to question the categories to which the symptoms are assigned.

Practicing presence involves developing habits of reflection, such as including in each day opportunities for complete silence and stillness. Stillness can be found during work-related tasks. It is a tool that performing musicians use - an inner stillness in order to project energy to the audience. Precious moments of repose occur even during a busy day-- the small moments of inaction between actions. The visceral learning from practicing stillness allows clinicians to experience that stillness when they need to call upon it (making the knowledge explicit) - to clear the mind before seeing the next patient, to perform a delicate procedure, or to listen more deeply to a disturbing story. Stillness apart from professional life might include doing meditation, observing nature or listening to music. This is not a "new age" or mystical process – it is a quality of mind that has been consciously cultivated by master clinicians, concert pianists and tennis champions. (16)

Self-monitoring

Self-monitoring refers to being aware of any disparity between intention and action, and between the imagined effect and the effect produced.

Self-monitoring refers to the moment-to-moment awareness of one’s intentions (e.g., to find out what's wrong) and one's actions (e.g. facilitating or cutting off conversations). Self-monitoring involves observing the observer at the same time you are observing the observed. Part of why this is difficult to do is that we judge ourselves harshly, and do not like to see that our actions sometimes diverge from our intentions. When we misunderstand a patient, make an error or suffer from ignorance, we feel badly. And, we tend to avoid in the future the types of situations that produced discomfort in us in the past. A skilled clinician anticipates the effect of a gesture or statement to a patient and carefully tracks the effect of that attempted communication – and if there is some evidence that communication has been inadequate in some way, makes corrections to achieve mutual understanding. (17)

Assessment and confirmation

We suggest that mindfulness be one criterion for assessment of trainees.

Patients may be able to assess "presence," and undistracted attention. Tolerance of uncertainty can be assessed through direct observation and debriefing. Evidence of curiosity is manifest in the use of reflective questions and "thinking out loud." You can set your personal expectations by saying, "Not only will I be looking at how I solve the clinical problems and how I relate to patients, but also I will be assessing how I reflect on my own performance." Peer ratings and self-ratings can be helpful. We can all learn to identify things that we have learned about medicine, or ourselves, in the course of caring for patients.

HEALTH SYSTEMS CAN EMBODY THE SAME PRINCIPLES OF MINDFULNESS AS INDIVIDUALS

A mindful approach to systems problems has some of the same characteristics as mindfulness in individual practitioners.(18) Mindful systems tolerate ambiguity, minimize errors and emphasize creative approaches to work.
A young man underwent a lymph node dissection for testicular cancer. After dissecting the left kidney, the surgeon turned his attention to the right kidney, and was no longer able to see the left one. A medical student in the OR noted that the left kidney began to turn a dusky blue color. Alarmed, he mentioned this to the attending surgeon, who denied that there was a problem and chastised the medical student for interrupting the operation. A few minutes later the kidney had turned a dusky violet color. The student spoke to the nurse, who relayed the information to a resident, and then to the surgeon. The surgeon attempted to restore blood flow, and ultimately called in a vascular surgeon to perform a delicate procedure to repair a tear in the arterial lining. The patient’s kidney function was abnormal following the surgery; the patient and family were told there was an unexpected and unavoidable complication of surgery.

Researchers of medical errors have focused on the structure of health care teams to find root causes of these errors. Chaotic process and faulty communication among professionals in the operating room led to an avoidable error, and organ damage worsened. The hierarchical team structure and an atmosphere of blame and retribution prevented early corrective action. In this case, the lack of mindfulness had ethical ramifications as well. The “cover-up” after the event was partially determined by the malpractice climate and advice from risk management personnel never to admit an error to a patient.

Mindful systems should be vigilant, and assume that systems tend to fail in unpredictable ways. For difficult problems, a tolerance for complexity and ambiguity will favor accurate observation and creative solutions, rather than oversimplification and premature closure. Critical curiosity – thinking “outside the box” – is characteristic of high-functioning individuals and systems. Brainstorming is one way of fostering curiosity, but only works if the ground rules include consideration of options that initially seem unorthodox. Administrators of large systems can easily lose track of the realities on the shop floor, and open, non-punitive communication can facilitate transparency of intent rather than hiding of errors. Systems can be set up that promote flexibility rather than reinforcing a single rigid process for dealing with problems. Flexibility, in turn, leads to greater suppleness and resilience. Finally, mindful systems include mechanisms to recognize that expertise and hierarchy may not be synonymous; the janitor may have a more accurate perspective on local infection control than the chief of the infectious disease service.

SUMMARY AND CONCLUSION

Mindfulness, a quality of clinicians and health systems, is fundamentally a set of habits of mind and habits of practice in the moment. These habits can be taught and learned, and professionals and systems who have these habits deliver very high quality medical care.

Mindful practice is an approach to self-knowledge and a component of professionalism, in the service of improved patient outcomes. These outcomes include patient health status, prevention of medical errors, patient trust and adherence to treatment, clinician growth and satisfaction, and lower health care costs. Mindfulness may be facilitated by exercises and forums outside the context of daily work but includes more than retrospective analysis of clinical actions. Many principles of mindful practice can be observed in master clinicians, even though they may not name it as such. Methods for fostering mindfulness in clinical practice can be successfully incorporated into educational programs.

APPENDIX 1: PERSONAL AWARENESS IN MEDICINE: QUESTIONS FOR PERSONAL REFLECTION
I. Core beliefs

What are my core beliefs about myself as a clinician? Why am I a clinician? What are my roles? For me, is medicine a job or a calling?

Do I have any of the following "dysfunctional beliefs"?

- limitations in knowledge is a personal failing;
- responsibility is to be borne alone by clinicians;
- altruistic devotion to work and denial of self is desirable;
- it is "professional" to keep one's uncertainties and emotions to oneself.

Family of Origin Influences

- What roles did I have in my family?
- How might I be replicating these roles in my work environment?
- What lessons did I learn from my family about the nature of relationships, about the nature of caregiving, and about acceptable responses to illness?
- What kinds of patients might I be likely to associate with family members?

Gender Issues

- What messages did I receive from my family and society about gender roles?
- How have my attitudes contributed to instances of miscommunication with others of the opposite sex?
- Are there any differences in the way I respond to male and female patients? In the way male and female patients respond to me?
- Do I respond differently to feedback from male or female colleagues?
- What messages did I receive from my family and society about gender roles?
- How have my attitudes contributed to instances of miscommunication with others of the opposite sex?
- Are there any differences in the way I respond to male and female patients? In the way male and female patients respond to me?

Sociocultural Influences

- To what culture do I belong and/or with what culture do I identify?
- What values come to mind that I particularly like and dislike as I reminisce about my cultural heritage?
- In reflecting on a cross-cultural interaction with a patient or colleague, what factors helped me feel a sense of congruence ("in synch") and/or a sense of dissonance ("out of synch").
- How has the 'culture' of medical training affected my attitudes?
- What is my institutional or practice culture and how does it respond to my needs?"

II. Clinicians' Feelings and Emotional Responses in Patient Care

Love, Caring, Attraction and Boundary Setting in Medical Care

- To what kinds of patients am I likely to get too close?
- What kinds of patients am I likely to keep at a distance?
- How do I react when family or friends ask me for medical advice?

Anger/Conflict
What sorts of patients elicit an angry reaction in me?
What work situations usually make me angry, and why?
What are my usual responses to my own anger and the anger of others? (e.g., Do I overreact, placate, blame others, suppress my feelings, become super-reasonable?)
What are underlying feelings when I become angry? (e.g., feeling rejected, humiliated, unworthy)
Where did I learn my responses to anger?
How would I change my angry responses to certain situations?

III. Challenging Clinical Situations

"Difficult Patients"
- What sorts of patients do I find difficult, even hateful?
- What is it about this patient that evoked strong feelings in me?
- Are there patients with certain diseases, eg., alcoholism, drug addiction, obesity, hypochondriasis that I find very difficult to work with? Why?

Caring for Dying Patients
- How would my personal experiences with loss and grief be likely to affect, enhance or limit my abilities to work with dying patients?
- What are my own attitudes and fears of death and vulnerability, and how might they affect my patient care?
- If I were dying, what would I want and need from my clinician?"

Medical Mistakes
Think about a mistake that you may have made, or witnessed.
- What was the nature of the mistake?
- What are my beliefs about the mistake?
- What emotions did I experience in the aftermath of the mistake?
- How did I cope with the mistake?
- What changes did I make in my practice as a result of the mistake?

IV. Clinician self-care

Balancing Personal and Professional Lives
- What would be an ideal distribution of time between work, play, family and personal growth and development?
- What are the barriers to achieving balance in my life?
- In what ways could my assumptions and beliefs be a barrier to change?
- In what ways is the current imbalance benefiting me, and would I be willing to give that up?
- What are some practical strategies, and steps I can take to achieve balance?
- How can I keep myself on track?

Preventing and Managing Stress/Burnout/Impairment
- How do I know when I am becoming "stressed out"?
- What positive strategies can I employ to reduce stress, or my reactions to stress?
- How can my significant others and friends help me avoid burnout?
APPENDIX 2: GOALS AND OBJECTIVES FOR MEDICAL STUDENT PERSONAL AWARENESS, GROWTH AND WELL-BEING

(From: Novack D, Epstein R, Paulsen R. Toward Creating Clinician Healers, Academic Medicine 1999 74;516-520)

Overall Goals:

- students should be aware of how their personal histories and current personal lives, their values, attitudes and biases affect their care of patients, and should be able to use their awareness of their emotional responses in patient care for their patients’ benefit.
- students should care for themselves physically and emotionally, and welcome and seek opportunities for enhancing their personal awareness and growth.

Objectives: Self-knowledge

By graduation, students should:

- have an increased understanding of their own psychological strengths and emotional triggers,
- have an increased understanding of how their own personality characteristics (such as gregariousness, needs for approval, tendencies to be judgmental, needs for perfection and control, etc.) affect their relationships with patients and colleagues,
- be able to articulate their core beliefs, ideals and personal philosophy of life, relating these to their goals in medicine,
- be aware of how family-of-origin, sociocultural and gender issues have shaped their attitudes,
- understand the difference between their feelings of sympathy and empathy for specific patients, and describe the personal and patient factors that enhance or interfere with their abilities to experience and convey accurate empathy,
- be aware of how their own spiritual beliefs may affect their abilities to relate to certain patients and to discuss spiritual issues with their patients
- understand their attitudes toward uncertainty, risk-taking and needs for reassurance,
- be able to describe how their relationships with certain patients reflect their attitudes toward paternalism, autonomy, benevolence, non-maleficence and justice,
- recognize their own feelings such as love, anger, frustration, vulnerability, and intimacy in "simple" and difficult patient-doctor interactions.

Objectives: Abilities

Students should:

- be able to create boundaries with patients that allow for therapeutic emotional connections,
- be able to challenge authority appropriately, from a firm sense of their own values and integrity,
- be able to respond appropriately to situations that involve abuse, unethical behavior and coercion,
- recognize their own limits and seek support and consultation appropriately,
- recognize and manage their own needs for power, perfection and control,
- be able to work collaboratively and effectively with colleagues and other members of health
care teams,
• recognize the warning signs of emotional ill health and be able to ask for appropriate help,
• be able to manage effectively their commitments to work and their personal lives, taking the
time to nurture important relationships, and themselves.

Objectives: Attitudes

Students should:
• be committed to the life-long processes of personal awareness, growth and well-being,
• be committed to using their insights and abilities in the service of enhanced patient care,
• be open to feedback from others as to how their attitudes and behaviors are affecting their
care of patients and their interaction with others

LITERATURE REFERENCES

effective patient care. JAMA. 1997;278:502-509.
4. Epstein R. Mindful Practice in Action (I): Technical Competence, Evidence-Based Medicine
5. Miller WL. Routine, ceremony, or drama: An exploratory field study of the primary care
7. Epstein M. Thoughts without a thinker: Psychotherapy from a buddhist perspective. Basic
Books; 1995.
8. Epstein R. Mindful Practice in Action (II): Cultivating Habits of Mind. Families Systems and
9. Connelly J. Being in the present moment: developing the capacity for mindfulness in
11. Novack D, Esptein R, and Paulsen R. Toward creating clinician healers: personal awareness,
13. McDaniel S, Landau-Stanton J. Family-of-origin work and family therapy skills training: both-
15. Engel G. What if music students were taught to play their instruments as medical students
are taught to interview? Pharos of Alpha Omega Alpha Honor Medical Society. 1982;45:12-3.
2005;20:201-207.
18. Weick K, Sutcliffe K. Managing the Unexpected: Assuring High Performance in an Age of
Rationale

Clinician patient encounters are therapeutic in and of themselves, independently of diagnostic
and therapeutic activities of proven effectiveness.

For thousands of years, before the modern era of efficacious drugs and other medical interventions, sick people have sought care from clinicians. Many of these patients experienced relief and started on the road to healing. How did this happen? If we can identify the therapeutic elements of clinical encounters, we can be intentional about maximizing these elements with patients.

There are several core concepts that help us understand the therapeutic efficacy of clinician-patient encounters: the biopsychosocial model, the importance of meaning, clinicians’ healing attitudes, and the healing power of caring in clinician-patient relationships.

Questions for Reflection:

- How can you promote healing of your patients’ illnesses, in addition to curing their diseases?
- What might get in the way of your expressing your caring to patients?
- In your own visits to clinicians, what have they done that promoted your trust, hope and relief of anxiety?
- What are your personal qualities that will promote healing in your patients?
- What are your dreams for yourself as doctor?

Key Principles:

- Clinical relationships can be therapeutic, independent of your biomedical diagnostic and treatment activities. You can enhance therapeutic and healing aspects of encounters by identifying windows of opportunity and employing specific interview skills in those moments.
- You can learn counseling strategies that help your patients cope with stress and illness and change unhealthy behaviors.

Learning goals:

At completion of this module, you will be able to:

- Describe core concepts underlying the therapeutic efficacy of the clinician patient relationship
- List the therapeutic goals of medical encounters
- Describe strategies that advance the therapeutic aims of your medical encounters
INTRODUCTION

Clinician patient encounters are therapeutic in and of themselves, independently of diagnostic and therapeutic activities of proven effectiveness.

For thousands of years, before the modern era of efficacious drugs and other medical interventions, sick people have sought care from clinicians. Many of these patients experienced relief and started on the road to healing. How did this happen? If we can identify the therapeutic elements of clinical encounters, we can be intentional about maximizing these elements with patients.

There are several core concepts that help us understand the therapeutic efficacy of clinician-patient encounters: the biopsychosocial model, the importance of meaning, clinicians’ healing attitudes, and the healing power of caring in clinician-patient relationships.

In the introduction section of this module you'll find the following:

- **The Biopsychosocial Model**
  The Biopsychosocial Model, first articulated by George Engel, (1) views people as integrated biological and psychological beings who behave in certain ways in their social contexts.

- **The Impact of meaning in medical care**
  All humans create meaning, all the time. The meanings that patients ascribe to symptoms affect their illness outcomes and ability to function well.

- **Holding and communicating healing attitudes**
  Clinicians are themselves “therapeutic instruments.” Your words and behaviors communicate your attitudes and are powerful change agents.

- **The healing power of clinicians’ caring**
  Perhaps the most fundamental of all healing attitudes is your caring for each patient.

---

The Biopsychosocial Model

The Biopsychosocial Model, first articulated by George Engel, (1) views people as integrated biological and psychological beings who behave in certain ways in their social contexts. Changes in any one of these dimensions of human functioning affect all of them.

The field of psychosomatic medicine has produced copious scientific evidence confirming the biopsychosocial model. (2) As examples, stress, depression and social isolation are associated with physiologic and anatomical changes that promote disease. Unhealthy behaviors such as smoking and drug abuse also promote the pathophysiology of diseases. The biopsychosocial model assumes the essential unity of mind, body and spirit. One way to understand this unity is to realize that thought, feelings, and abstract reasoning are also neurobiological processes. While you are reading this, neurochemical processes are being stimulated in your brain. Basic changes in m-RNA and neurotransmitter metabolism are occurring as new information is being processed. If your feelings are aroused, neuroendocrine mechanisms are affecting other bodily processes. All of which, in turn, can affect your behaviors, as well as basic physiologic processes that modulate immunity and innumerable body functions. Thus, in thinking scientifically about illness and disease, you must consider the biological, psychological, behavioral, and social factors that contribute to your patient’s illness. You can learn to use your understanding of biopsychosocial interactions to counsel
your patients so they can change their reactions to stress, recover from depression, reengage with their loved ones and community, and change maladaptive behaviors.

One practical exercise that you can do to understand how a biopsychosocial approach can be useful with individual patients is to ask the question, “why is this patient ill now (as opposed to 6 months ago or 2 years from now, or never)? The answer to this question often reveals an interplay of biological, psychological and social factors in a patient's life. For example:

In my (Dennis Novack) doctoring curriculum for medicine interns, we interview a random patient on the wards to see if we can answer that question. We interviewed a 55-year-old woman in her street clothes who was about to be discharged from a four-day admission for severe abdominal pain. The workup had proven inconclusive. When we asked her about recent stress in her life, she revealed that she was currently the main caregiver for her mother-in-law, who was currently dying from ovarian cancer. Caring for her mother-in-law was difficult enough without much help from other family members, and while trying to maintain a full-time job. However, it was also the one-year anniversary of her mother's death. She had also been very close with her mother, who had died of pancreatic cancer. Both her mother and mother-in-law had experienced a good deal of abdominal pain. We explained to her how stress can cause G.I. cramping, and talked with her about how she could possibly get some support for her caregiving role.

Another patient demonstrated how personality and social factors contribute to presenting for care: We interviewed a 29-year-old woman with widely metastatic choriocarcinoma. She was pale and weak, and could not sit up. We asked her when she had noticed that her health wasn't quite right. She replied that she knew something was wrong about 8 or 9 months previously. However, she is a single mom without insurance and had to work 2 jobs to support her 3 children. She was determined that she could not be sick and did not seek care. One day, she could not get out of bed, and one of her children called 911.

---

**The Impact of meaning in medical care**

All humans create meaning, all the time. The meanings that patients ascribe to symptoms affect their illness outcomes and ability to function well. The meanings we ascribe to our patients’ illnesses and behaviors affect our interactions with them. Clinicians have many opportunities to use skills for helping patients understand symptoms, reframe meaning and cope with illness.

The way people experience illness is a function of both their somatic alterations (i.e. changes in their anatomy, physiology, biochemistry, etc.) as well as a host of psychological, social, and behavioral factors. The experience of illness depends on what patients say to themselves. Illness is associated with symptoms which trigger a series of thoughts, beliefs and concerns as well as emotional and behavioral responses. For example, in predisposed individuals stress may precipitate contraction or spasm of temporal or cervical muscles, causing a headache. Some will think of this headache as a minor nuisance that will eventually go away on its own, while others may become concerned that it signifies a serious underlying problem like a brain tumor. These concerns can lead to feelings of anxiety as well as maladaptive behaviors, such as more vigilant monitoring of symptoms and decreased activity or social isolation. This sets up a vicious cycle that is likely to worsen symptoms and dysfunction.

Many factors influence how people ascribe meaning to a symptom. Some people view their symptoms in a pessimistic manner (e.g. it will never get better) while others think about the same health problem more optimistically. People vary in their perceptions about their ability to control health problems. People with a high level of self-efficacy take remedial steps on their own, while those with lower self-efficacy rely on others, such as mothers, clinicians and alternative healers.
Attributions about causes of health problems vary as well, and some people blame themselves for the cause of problems. Some believe the cause will never change, while others see the cause as a temporary phenomenon. Some people feel their illness affects everything about them (e.g. if I have diabetes I must be a sick person) while others think of health problems as but one aspect of who they are (e.g. I am an energetic, vital person who happens to have diabetes). The reactions of family, friends and clinicians can reinforce the sick role and further increase patients’ concerns, and ultimately both the severity of symptoms and the level of dysfunction. Stressful events or social isolation may deplete the person’s ability to adequately cope with new health problems.

In our role as caregivers, we also attribute meaning to symptoms and patients’ behaviors, and need to be aware of our attributions so that we can provide the objective and unbiased care. (See module 2) Additionally, clinicians can respond helpfully to meanings patients ascribe to sickness, reassure them, educate them, reframe their situations so that they see new meanings in their illnesses, and guide them to adopt healthy behaviors.

---

**Holding and communicating healing attitudes**

Clinicians are themselves “therapeutic instruments.” Your words and behaviors communicate your attitudes and are powerful change agents. To become maximally effective, you must “calibrate your instrument.” (4)

You must ask yourself if you are fully committed to your patients’ healing and well-being, and whether you have the ability to express a sense of caring in words, nonverbally and in deeds. If you feel hope, optimism and caring toward your patients, your activities have a high likelihood of being helpful. If you feel annoyed with certain patients, or feel judgmental about their inability or unwillingness to change unhealthy behaviors, your words and manner inevitably communicate those feelings and undermine your therapeutic efforts. If you are not able to communicate empathy and interest in the patient as a person in a particular situation, your good intentions are much less apparent to patients.

Your patience, tolerance and generally positive outlook will be frequently tested. For example, you may need to make patients unhappy or angry, such as when communicating unpleasant news, or telling them crucial information, (e.g., “I think your diagnosis is alcohol dependence,” or, “Your bone scan shows that your cancer has spread.”) If you focus more on your fear of hurting patients’ feelings in the moment than on caring for them over hours, days or years, you will temper your message and be less effective. If you find yourself less than fully committed or lacking certain abilities, you may need to “recalibrate your instrument,” that is, strive to understand your values, attitudes and biases as they become barriers to your care and to learn skills to communicate your caring in a broad range of challenging situations.

For example, one clinician reported, “I was working up a patient who is newly admitted for an AIDS-related illness. He was a 33-year-old man who had also been previously admitted for infections related to his IV drug abuse. When I asked him how he afforded his medications, he replied, “I do home invasions.” I looked at him in surprise, “home invasions?” I asked. He said, “yeah, I break into people’s homes, hold them at gunpoint, tie them up, and take their things.” I suddenly felt a sense of anger and outrage at the suffering that he caused others, which I have to say limited my pity for his obvious distress.”

How can you, as a clinician, put aside your judgments and negative emotional responses to treat all of your patients with compassion, and to envision and promote healing of their illnesses? If you believe that all of your patients have the possibility of redemption and healing in their futures, you will be more effective in offering them hope, which is perhaps the most motivating of all human emotional states.
The healing power of clinicians’ caring

Perhaps the most fundamental of all healing attitudes is your caring for each patient.

Peabody observed, in a famous address to Harvard medical students in 1925 (5), that "...the secret of the care of the patient is in caring for the patient." When patients are ill, they are often hurt, apprehensive and confused. Independent, self-sufficient people will lose confidence, become dependent and may regress in their relationships with others and with their clinicians. They yearn to be taken care of, to experience the comfort and caring of a loving parent. Patients will often "project" that need and see their clinicians in a parental role. Though you may be a medical student, resident or young attending, even elderly patients will often unconsciously see you in that way. To the extent that you can express your caring, your support, your understanding, your willingness to be with the patient whatever comes or whatever they say, you will be providing comfort, safety, reassurance and healing.

Expressing your caring can assist you to listen and become present with another person. Many clinicians in practice have the experience of patients staying alive, or not giving up, because they have clearly expressed their caring to the patient in words and deeds. Many have experienced their patients’ appreciation in return, which reinforces the “caring” attitude, nourishes the healthy human cycle of people caring for each other, and enriches clinicians’ lives and work.

Many of you said to your medical school interviewer, "I want to help people," or other expressions of your desire to care for others. Sometimes this core value gets suppressed by the stresses and demands of medical education and patient care. Many students and clinicians can at times become cynical or burnt out. Depression and anxiety are more common among medical students and clinicians than in the general population. It is so important to care for yourself (please read module 4) so that you can be fully present for patients, express your caring to patients, and stay connected to your core values as a clinician.

Other key concepts

There are other features of doctor-patient relationships that from time immemorial have promoted healing.

Other concepts help explain the survival of medicine as a profession through the thousands of years of few efficacious remedies for diseases. These all relate to clinician's words and behaviors:

**Listening:** Think about your experiences of being truly listened to, and how that has been helpful to you. We are social creatures, and depend on each other for support and sustenance. Clinicians have always been able to listen, understand, and offer emotional support, which can help patients feel less isolated and more hopeful.

**Allaying anxiety, sadness, and grief:** Illness often creates a much anxiety and sadness, as well as grief reactions for lost functionality. To the extent that clinicians' reassurance can help lessen these emotions, the distress that worsens a patient's sense of dis-ease, or illness, also can abate.

**Allowing/facilitating emotional expression:** All recognize the often salutary effects of a good cry. To the extent that a clinician allows and facilitates a patient's emotional expressions associated with stress and illness, patients can often feel a sense of relief and a lessening of
Giving an explanation: Uncertainty is a disturbing emotional state. When clinicians give diagnoses and prognoses, patients can feel reassured that there is something to do or that can be done to ameliorate the illness, and are able to plan accordingly for the future.

Offering hope: Hopelessness is one of the most noxious of emotional states, and associated with negative physiologic processes as well. Hope is motivating and contributes to the healing process. Clinicians can always offer hope, if not of a cure then perhaps of relief of pain and lessening of suffering.

Touch: All healing disciplines have used touch, including "laying on of hands," massage, or simply putting a hand on a shoulder as a gesture of reassurance. Touch can be a powerful nonverbal expression of a clinician's concern and caring.

Using the placebo response: Because of modern neuroimaging, we now know some of the neural circuitry underlying the placebo response. These processes are complicated, and involve dopaminergic and opioidergic systems in the brain. (14, 15) Also, the likelihood of being a placebo responder is to some extent hardwired. Clinicians throughout time, though, have always been able to invoke the placebo response, using their words to engender hope, positive expectancies, and behaviors that reinforce progress toward the healing of illness. All of these processes are part of the placebo response.

**THERAPEUTIC GOALS OF THE MEDICAL ENCOUNTER**

The specific therapeutic goals of the medical encounter are to:

1. recognize and understand the full extent of the patient's health problem(s),
2. promote effective patient participation in their care,
3. modify maladaptive health behaviors,
4. facilitate patients' efforts to cope with their disease and other stressful life events,
5. improve patients' satisfaction with their care and their health status,
6. enhance patients' self esteem and well-being.

In so doing, clinicians will derive certain benefits as well, these benefits include:

1. attract and retain more patients,
2. decrease their risk of medical malpractice suits,
3. increase their sense of professional satisfaction.

The process of accomplishing these goals involves six tasks. Clinicians need to: 1) understand their patients and their health problems, 2) demonstrate interest and concern, 3) inform and involve the patient in their care, 4) provide counseling, 5) create trust and confidence, and 6) demonstrate support and respect. There are a set of strategies clinicians can use to accomplish each of these tasks. These strategies may be designed to change the way a patient thinks about their problems (i.e. cognitive strategies), the emotional distress that has contributed to or resulted from their health problems (i.e. affective strategies) and the maladaptive behaviors associated with the problem, (i.e. behavioral strategies). In the remainder of this module, we will review each of these therapeutic tasks and discuss how they can be accomplished during the medical encounter. These tasks are well covered in the modules to follow, but we will highlight some of the essentials.

**Understanding Patients and their Health Problems**
This is a major task in the therapeutic process. Achieving a comprehensive understanding of the factors contributing to the onset and maintenance of a patient’s illness guides therapeutic interventions. How are patients’ stressful life situations, emotional states, personalities, past histories of trauma or abuse, financial worries, etc. contributing to the illness?

By the end of your interview with patients, you should have a good understanding of the biological, psychological, behavioral and social factors that contribute to the onset and maintenance of their illnesses.

Patients seldom hesitate to express somatic symptoms, but are typically more guarded both in disclosing emotional symptoms or stressful life problems, and unveiling pertinent details. These problems in patients' lives are common however, frequently not recognized, and they can cause or contribute to the patient's health problems. It is also important to understand patients' beliefs and concerns, goals and expectations for the management of their health problems. These issues will usually not be discussed unless you directly ask. Evaluating these issues can facilitate more effective and more satisfactory management decisions. For example, a patient who presents with a headache may have one or more of the following five goals in mind for the visit: 1) obtain something from the clinician to relieve the symptom, 2) learn how to prevent headaches from recurring, 3) reassurance about the cause of the headache, 4) receive help for the stress that is causing the headache, 5) obtain administrative help like a note for work. Each of these goals will require a different set of management strategies. Failure to recognize a patient's goal(s), concerns, and expectations often provide in ineffective and unsatisfactory care.

Understanding these aspects of the patient's problems requires that you begin by asking open ended questions and give patients sufficient time to fully respond. Skills that facilitate a comprehensive response to an open question like, "How have you been doing since your last visit?" are discussed in module 8. Usually, you have to ask directly about patients' beliefs (e.g. "What have you thought might be causing your problems?"), concerns (e.g. "What concerns do you have about this problem?"), goals (e.g. "In what ways do you hope to benefit from addressing this problem today?"), and expectations (e.g. "What types of things do you feel we might do to help you with this problem?") (6) Module 9 discusses “understanding the patient's perspective” in greater depth.

It is helpful to cultivate the skills of attending to patients’ cues and clues, and following up with nonjudgmental and respectful further inquiry. For example, very often people mention "stress," or say at an odd point, "My uncle (neighbor, friend, etc) had liver cancer," without further elaboration. They are not sure you will be interested, or worried that you will think their concern unimportant. If you miss the cue, they may feel ignored, and trust in the relationship will be a little (or a lot, depending on details) eroded. Asking how the stress has been affecting them, both physically and emotionally, and whether or not it impacts their normal activities; or why they brought up the uncle just now may reveal information that enables you to minimize tests and consultations, and save time, and foster the healing relationship.

---

**Psychiatric illness**

Dissociation from feelings, treating people as objects and feeling ineffective are the usual symptoms of burnout.

Importantly, the responses to clues sometimes help point toward the need for a diagnostic assessment for a mood or anxiety disorder. Other clues that suggest that patients should be screened for depression (see module 27) or anxiety (see module 26) before further workup for obscure or unlikely somatic diseases include the following:

- patients who appear sad, agitated, or anxious
patients with three or more unrelated somatic symptoms
patients with nonspecific symptoms like decreased energy, headache, or fatigue that do not relate to other somatic symptoms or physical findings; or with chronic abdominal pain and a negative workup
patients whose symptoms are out of proportion to their objective findings
patients who fail to improve as expected
patients who fail to adhere to agreed management plans

While it is important for you to understand your patients' problems and their perspective on these problems, it may be just as important to communicate this understanding to your patients. Without doing this, your patients may not appreciate that you have understood the nature and the severity of their problems or their concerns, goals, and expectations about them. You can communicate your understanding by briefly reviewing what you have learned and by expressing empathy (i.e. I can understand how difficult this must be for you) and legitimation (i.e. given this circumstance, it is normal to feel the way you have been feeling.).

---

**Create trust and confidence**

Patients' positive health outcomes strongly correlate with high levels of trust in their clinicians. This is probably because trusting patients both follow plans they feel involved in generating and also feel empowered to ask questions when uncertain or worried. (7)

Patients with greater trust in their clinicians are more satisfied with their care, more likely to adhere to their clinician’s recommendations, and less likely to change clinicians. Trust comes from the successful accomplishment of many of the tasks in the therapeutic process - for example, understanding patients and their problems, demonstrating interest and concern and informing and involving patients’ in the decision making process. One study that supports this idea surveyed patients who had a first visit with a cardiologist, neurologist, nephrologist, gastroenterologist, or rheumatologist at a Harvard medical school faculty practice. (8) In this study, 79% of patients reported complete confidence and trust in the specialist. Patients who were more trusting reported that specialists listened, gave as much information as patients wanted, instructed patients about what to do if problems or symptoms continued, got worse, or returned, involved patients in decisions as much as patients wanted, and spent as much time as patients wanted. Patients highly value clinicians who outline management options, explain the risks and benefits of each option, and offer patients opportunities to participate in decisions about their care. Patients and clinicians should be clear about the goals of care and these goals must be realistic. Patients understand that not every diagnosis is accurate and not every treatment works, so they want to know how to monitor their course and what to do if things don’t go as expected. Establishing this type of safety net greatly enhances trust.

---

**Demonstrating Interest and Concern**

Making obvious your interest in the patient as a special person is the central task in establishing a healing and therapeutic relationship. Patients are more trusting, cooperative and satisfied; and your work is simpler, more efficient, timely, accurate and satisfying.

Giving attention to enhancing your relationships with patients results in more trust, more optimism about plans and better adherence to them, easier resolution of conflicts, and more open and frank discussion of difficult topics, such as bad news, sexual problems, or post-operative complications. Patients are more satisfied, your work is more efficient and malpractice suits less likely. For many patients, your personal attention imparts a refreshing boost in self-esteem, so central to getting on with life. We briefly review the skills for accomplishing this central task. More depth and additional
strategies are presented in Module 6.

Demonstrate your interest by spending a few moments at each visit getting to know your patients’ social situations, job, hobbies and interests. Engaging in this more personal relationship not only makes your work easier (as above), but it reminds you that you are taking care of a person not simply another “case” of hypertension.

**Use multiple strategies to demonstrate concern**

Commit yourself to expressing your interest verbally, non-verbally and in small gestures.

Display your commitment to patients by going out of your way to provide services that are not strictly required. For example, communicate results of tests in a timely manner, call to see if they are feeling better or have quit smoking. Such simple gestures can easily become part of your routine, and patients appreciate these expressions of your concern for their well-being.

Communicate your interest directly by expressing support and partnership in difficult situations. For example, if you determine that a patient has depression, but is not willing to accept treatment, you can communicate your support by saying, “I am interested in helping you, even though you are not ready to do anything right now. Come in any time you wish and we can figure out together how to help you feel better.”

Express your interest non-verbally as well. For example, in hospital you can sit down at the bedside. Taking a moment to pull up a chair, and maintaining eye contact reveals your concern, whereas standing up creates the impression that you wish to leave as soon as possible. Module 14 describes additional non-verbal skills that communicate concern.

**Informing and Involving Patients in their Care**

Information about a patient's disease and its management can be helpful or overwhelming, and is easily forgotten. Tailor the information you provide so that it enables patients to understand diagnosis and management plans. Encourage patients to participate as much (or as little) as they like in their own care.

Providing information about patients’ disease and its management (see Module 10) can relieve anxiety, promote greater adherence to the management plan, and increase patient satisfaction. Patient education also enables patients to monitor their treatment outcomes and appropriately respond if they fail to improve as expected. Informed patients can more easily play an active role in decisions about their care. The process of educating patients begins with an assessment of their beliefs, concerns, and need for information. (9)

All patients want to know their diagnosis and management plan, but not all want to understand the pathophysiology or the pharmacology of their medications. Some patients cope with stressful situations by monitoring their environment for information about that situation. More information is comforting, even though it may not enable them to do anything differently. Other patients prefer not to focus on gathering more information, because going beyond just the basic information provokes additional stress.

Never assume that patients will understand, believe, or remember what you tell them. Evidence shows that patients do not understand (or forget) about half of what you tell them. You can increase their understanding and adherence to management recommendations by providing them
with educational handouts, by writing down the things you both agree that they will do, and by asking them to review what they have learned and what they plan to do as a result of your discussion. The skills and strategies are described in Modules 11 and 12.

---

### Provide supportive counseling

Counseling interventions to help people cope with health problems and to help them follow plans are among the most cost-effective things a clinician can do to prevent disease and improve health status.

Supportive counseling helps patients change unhealthy behaviors, and helps them cope more effectively with health problems or stressful life events. Counseling goes well beyond providing information, but giving information skillfully is the foundation of excellent supportive counseling. Counseling is an interactive process that includes assessing patients' perceptions and self-efficacy, attentive listening about values, priorities and goals, problem-solving about barriers and obstacles, and reaching agreement on negotiated goals (as opposed to your prescribing the goals). Aspects of counseling are given more space in Module 16 and other modules that discuss specific problems (such as alcohol, sex, end-of-life care, talking about mistakes.)

---

### Stress Management

Patients want clinicians to help with psychological distress. Discussion and ventilation with an attentive listener helps. Clinicians who add empathic statements increase their ability to decrease emotional distress.

About 60% of primary care patients indicate that it is at least somewhat important that clinicians help them with their psychological distress. Most patients seek an opportunity to discuss the stress in their lives. (10)

Effective approaches can be applied during a medical encounter, despite the limited time of visits. (11) Discussing the stress in the patient's life and encouraging emotional expression can have considerable therapeutic value. (12) Talking about a stressful situation with an attentive and reflective listener encourages patients to examine situations more carefully, and they may recognize that things are not as dismal as imagined. Simple ventilation of strong emotions to a nonjudgmental listener often provides relief. This activity enhances trust and prepares the ground for additional assistance, as the patient senses that "my doctor cares about me."

The therapeutic benefits of simple discussion and ventilation are enhanced when clinicians demonstrate their caring by making reflective statements (e.g. "I see that this is very difficult for you"), legitimation (e.g. "it is normal to feel the way you do"), support (e.g. "I am here to help in whatever way I can"), partnership (e.g. "we can figure out how to deal with this together"), and respect (e.g. "I am impressed by your clear thinking about this problem"). (See Module 6)

---

### Decide what you might do in addition to listening

Broadly speaking, deciding whether patients need help with problem solving, changing their thinking about distress, or discovering ways to better cope helps you organize your interventions.

As you listen to the details, you should decide whether patients need help with problem solving,
modifying negative cognitions about themselves and/or their problem, or finding adequate coping strategies.

Problem solving includes several discrete steps: help patients identify goals (e.g. how will they benefit if they can change a stressful situation); brainstorm possible approaches and their likely outcomes; explore barriers to implementing these approaches; select an approach and develop an implementation plan; and monitor progress and outcomes. Your role in this process is primarily to guide patients in organizing their thinking and strategy, and working out each step by asking them questions (e.g. "what are the ways you have thought about to resolve this problem?") You may provide options or suggestions, but ultimately, patients must make the hard choices themselves about the best course of action.

### Help patients change their perspective

People who change how they view problems reduce their distress without changing the situation itself. You can help patients explore their attributions of causality and of the potential for relief, and help them examine which specific life functions are actually disturbed.

Many stressful problems can't be resolved, but you can help reduce patients’ distress through helping change patients' thoughts (“cognitions”) associated with these problems. Patients who make internal attributions about the cause of the problem (e.g. "I did this to myself; I caused this") experience more distress. Patients who also make stable attribution about its cause (e.g. "it will never get better") and global attributions (e.g. "it affects everything about me") compound their distress. These patients, who persistently believe that they are guilty or a failure, or that the inevitable result of a situations is complete disaster can be encouraged to more critically evaluate their beliefs. In addition to attentive and empathic listening, you can ask patients to reflect on why they are making these attributions, whether any evidence supports the attributions, and what other attributions about causes and effects might be possible. Many clinicians make the mistake of trying to reason with patients and persuade them that their thinking is incorrect. The dynamics of cognitive thinking predict that you will always fail to persuade; you can only assist patients in organizing their reflections on their cognitions, and coming to their own conclusions.

### Suggest additional simple coping strategies

Additionally, clinicians can help patients adjust expectations, engage in rewarding activities, and make use of support networks.

Clinicians can suggest strategies that will help patients cope more effectively, whether or not they plan to seek resolution of the problem or adjust their cognitions. One tactic is to encourage patients to readjust their expectations. Distress can be envisaged as the gap between expectations and reality. When problem solving fails to modify the reality and bring the situation more in line with expectations, you can help patients close the gap by readjusting their expectations. A second tactic is to encourage patients to more frequently engage in activities that are pleasurable, relaxing, or rewarding. Positive activities provide things to look forward to and deflect attention away from the negative situations, a kind of counterweight that balances against stressful problems. A third tactic is to encourage patients to take better advantage of their social support network. You can ask patients to identify the people in their life that they turn to for support. Sometimes patients have not shared their problems with family and friends, and need your encouragement to do so and to accept their support. We stress again that you cannot persuade patients to do any of these things, but when you present your ideas and suggestions in an empathic way that encourages reflection and dialog, you will have a positive effect.
Provision of effective reassurance about health concerns

Health concerns cause stress. Patients often seek care primarily for reassurance about these concerns. Your full and empathic evaluation of the problem (even problems that seem biologically very minor) and the beliefs and concerns forms the firm foundation for reassurance. (13)

The vast majority of patients with minor problems like an upper respiratory tract infection do not seek care. Those who do are usually more worried than patients who decide to manage the problem on their own. Ask questions like, "What have you thought these symptoms might be due to?" Patients’ answers will alert you to their might desire for reassurance and give you information about their specific concern. (see Module 9)

When your initial impression is that reassurance would be appropriate, strive to more fully understand the basis of the concerns. Ask, "What makes you think this may be a serious problem?" and "What worries you the most about this problem?" Patients will not accept reassuring statements unless they believe that you fully understand that their symptoms are distressing and complex and mystifying. Consequently, giving them time and prompts to fully express their symptoms, and then expressing your understanding by summarizing what you have heard and making an empathic statement (e.g. I can really understand how difficult these symptoms must be for you) not only gives you important data about the situation, but forms the foundation for effective reassurance. (See Module 8)

After you complete these explorations and show your understanding, educating patients corrects erroneous beliefs and provides the rationale for your conclusions and reassurance. (see Module 10) Discuss with patients about indications that a reevaluation or a change in management might be in order. We can with full confidence tell a patient that her headaches do not indicate or mask a more serious hidden problem, but we can rarely be one hundred percent certain about this. Patients appreciate a list of specific findings they can use to determine if further evaluation is indicated. In this situation, you might tell her to come back for additional examination if the headaches increase in frequency or severity, fail to improve over the next two weeks, or wake her from sleep.

When you must temper your reassurance, or it is rejected by patients

Some patients accept your rationale and reassurance but others do not. The only way you can determine which patients are reassured is to ask them. You can ask, “How worried are you now?” and, “Are you thinking we should do additional tests at this time?” If patients still desire diagnostic tests, you can choose to perform tests if risks and costs are minimal and you think that the therapeutic benefit of the reassurance will be substantial. Because the therapeutic benefit is usually small and always hard to predict, you better serve your patients by giving a clear rationale for not testing, responding to their feelings (see Module 13) with empathy and support about the “bad news” (see Module 33) that you will not test right now, and negotiating a mutually agreeable follow up plan. (see Module 11)

Sometimes patients’ concerns are appropriate to the potential seriousness of their problem. Do not provide false reassurance, and also do not discuss all the potential consequences until you are more certain of the outlook. To the degree that is realistic, your most important function is to be clear that optimism and hope are in order. The hope you provide should be consistent with a realistic set of goals. Do not raise the hope of patients with metastatic cancer that they will live
another X years, but reassure them that they will not experience much pain and that with your
support, they will remain in control of decisions about their care. (See Module 34) Expressing your
compassion and your ongoing personal support (“non-abandonment,” see Module 33) is in itself a
way to increase patients’ hope.

**Modifying maladaptive and unhealthy behaviors**

You can help patients change unhealthy behaviors, and make a big difference in their current
and future health. There are helpful concepts, and a number of skills that you can learn that
will promote behavior change.

Many major health problems result from unhealthy or maladaptive individual behaviors that are of
complex origin and extremely resistant to change. These include smoking, drinking, drug abuse,
gambling, and domestic violence, to name a few. You may find it hard to understand why patients
do not follow plans they have agreed to- they often do not keep appointments or see consultants,
fail to take medications or accept your recommendations for procedures.

You can learn specific skills for assisting with behavior change. Promoting behavioral change is
presented fully in module 16 and counseling related to specific behaviors is discussed in module 24
(smoking cessation), 25 (diet and exercise), 29 (alcoholism), and 30 (drug abuse). In this section
we summarize essential points of counseling for behavior change.

Your initial challenge is to establish a strong relationship with patients, and then to develop the
skills for quality patient education, exploration of motivational factors and appropriate counseling
strategies. It is important to preserve this relationship by not being judgmental or threatening
when discussing the need to modify a patient's behavior. Avoid lecturing patients about the
adverse consequences of their behavior, since most patients will already know much of this
information. It is usually much more effective to begin by empathizing with the difficulty of
changing behavior and then to ask patients what they see as the benefits to them, if they were
able to change the behavior, and then to assess their level of motivation to change their behavior
at this time.

Patients who are not ready to change their behavior will need motivational counseling. Two types
of issues can prevent patients from being ready to make the effort to change a maladaptive
behavior. First, they might not fully comprehend the risks associated with that behavior and the
benefits of changing it. In addressing this issue, you should remember to take advantage of the
Teachable moment (i.e. any time the patient is already experiencing an adverse consequence of
the behavior you wish to change). You can highlight the relationship between this behavior and
this problem. Before adding more reasons why the patient should change their behavior, ask the
patient about their understanding of the current and future consequences of this behavior and the
benefits of changing it. This type of information will be more persuasive if the patient says it rather
than if you say it. In discussing the benefits of changing the behavior, it is often more effective to
emphasize more immediate benefits (like saving money if you quit smoking) then the more remote
benefits that won't happen for a long time and don't happen to everyone.

Patients often fully understand the need to change their behavior, but still seem reluctant to try to
attempt to do so. This is usually because they don't think they will succeed if they try. For them,
the barriers to change are perceived as too great. This, therefore, is the second issue that needs
to be addressed. The key question to ask is "What makes changing this behavior hard for you?"
Once you understand their barriers to change, you can begin to help your patients develop a plan
to overcome their barriers. In developing this plan, several principles must be kept in mind. First,
try not to tell patients what to do to overcome their barriers, but rather help them figure this out
for themselves. Sometimes it is necessary to provide patients with options, but after listing a few
strategies they might employ, it is important to ask if any of these strategies sound like they might
work for them. The second principle is to keep the plan simple. If it sounds too difficult, patients
won't try to do it. For example, if you tell a patient who is concerned about weight gain if they try to quit smoking that they can overcome this barrier by exercising, the patient is likely to conclude, "why bother? It is hard enough to try to quit smoking. I don't think I will be able to also start an exercise program.” The third principle is, make the plan as specific as possible. Telling a patient that they should diet and exercise, will have little meaning and effect, unless you can negotiate specific changes in the patient's eating habits and a specific plan to exercise that includes the type of exercise, frequency, and duration.

You can also increase your patients' sense of control over the target behavior by discussing the reasons why you believe they can be successful, if they try. You might mention other successes the patient has achieved, your support for this effort, and the plan you will develop together. If the patient has tried to change their behavior in the past, you can explain that behavior change often involves several unsuccessful efforts before you finally succeed. Each time you try however, you can learn something from that effort that will help you the next time you try to change your behavior. You can then review what patients have learned from previous efforts to change their behavior and what they can do differently this time. The more confidence patients have about their chances to succeed, the more motivated they will be to try to change their behavior.

When developing a behavioral change plan, several issues should be addressed. First, the goals should be explicit and realistic. Patients should not be merely told to lose weight, but should be informed that an appropriate initial goal might be to lose 5% to 10% of their body weight since this will achieve most of the medical benefits from weight loss. Second you should ask the patient to set a behavioral change date. This will provide structure and let you know when to see them in follow-up (usually one to two weeks following this date). Third, you need to help the patient create an environment that will support their effort to change their behavior. For cigarette smokers for example, this means getting rid of cigarettes, ashtrays, and lighters and telling everyone they know in advance, that they are quitting and that the cigarette smokers can help them by not smoking in front of them and not giving them any cigarettes. Third, you should help the patient identify their barriers to change and the things that trigger the maladaptive behavior and then develop a plan to overcome their barriers and either avoid their triggers or not succumb, if they are exposed to them. Fourth, the behavioral change plan should include rewards that highlight the benefits of their efforts. Patients who quit smoking can gain a greater appreciation of the financial benefits of smoking cessation by setting aside the money they would have spent on buying cigarettes and using that money every week to reward themselves. Fifth, patients should be encouraged to identify people who can support their efforts to change their behavior and to use them as needed. Finally, the plan should include ongoing follow-up and monitoring in the clinician’s office and possibly in a community based program.

CONCLUSION

Health problems and their associated symptoms develop out of a complex process that not only includes biological factors, but also patients’ beliefs, feelings and behaviors and the interpersonal and intrapersonal factors that can affect them. Bio-technical interventions can modify the underlying somatic alterations that contribute to these health problems. The beliefs, concerns, emotional distress, and behaviors are most effectively addressed in trusting and supportive relationship with the clinician, through communication about the issues.

The therapeutic value of the encounter itself can be maximized by focusing on six essential tasks:

- striving to fully understanding patients and their health problems
- building trust and confidence
- demonstrating interest and concern
- informing patients fully, and involving patients in their own care
- providing counseling to relieve stress and health concerns and modify maladaptive behaviors
- demonstrating support and respect even in difficult circumstances
A variety of cognitive, affective, and behavioral strategies are suitable and available to accomplish each of these tasks. The effective application of these strategies will lead not only to improved outcomes of care, but also to increased professional satisfaction and practice growth and a decreased risk of malpractice litigation.

LITERATURE REFERENCES

Module 04: Balance and Self Care
by John F. Christensen, Ph.D.

© 2005-2014 by AACH, Drexel University College of Medicine and others - see copyright info for details

"DocCom" is a joint production of the American Academy on Communication in Healthcare and the Drexel University College of Medicine. It is made possible by a generous grant from the Arthur Vining Davis Foundations.

Module 04 Credits:

Author: John F. Christensen, Ph.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Clinician on camera: John Christensen, Ph.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.0 - 12/7/2011 (HTML5 enhanced)
2.0 - 7/7/2009 (upgrade to DocCom version 4.0)
1.0 - 6/27/2005

Relevance

Medical education and the medical profession are stressful endeavors, with high rates of burnout and mental health problems, including substance abuse. We will be satisfied and effective clinicians only if we find healthy methods for coping with stress.

We cannot reach our potential as healers if we ourselves are unhealthy in body, mind or spirit. We cannot be fully present for our patients or colleagues if we are depressed, anxious, or distracted by personal problems.

In this module we explore the landscape of personality, study, and demanding professional work through three stories. We examine ways that Jill, a medical student; Bill, a resident; and Lisa, a young practicing clinician, strive to find and sustain professional satisfaction and personal well-being. Personal issues and challenges at each stage of professional development are different but overlapping. Jim, Bill and Lisa each cope with stresses and grow personally and professionally through engaging in personal reflection and seeking counsel. We comment on psychological and social factors that influence their attitudes and behaviors, and on the healthy choices and strategies they develop to align their actions with the values they cherish.

Questions for Reflection:

- Do you have a mentor at the present time? If not, with whom might you explore and discuss opportunities and barriers to finding someone to fill this role?
- Do you regularly keep a journal, or in some other way incorporate a regular time of reflection or contemplation into your day (week?)
- Do you have any routine rituals or practices that help you center yourself and be present to the moment, especially when you are working hard?

- Do you regularly schedule time off from work/study activities?

- When have you been at your best—thriving personally, energetic, satisfied with life, and hopeful of your future? What did you learn from this experience that has relevance for your future well-being?

- Do you disclose your feelings to your intimate partner? Your friends? Your colleagues or teammates? Is it difficult or easy for you to make empathic statements?

- What positive influence could you have on the nature of your learning or work environment?

- How do you care for your physical health—do you attend to nutrition, exercise, and sleep? What about alcohol, recreational drugs, or tobacco? Do you have your own primary care clinician?

---

**Key Principles:**

- Well-being is at the positive end of a continuum of life satisfaction that includes burnout at the negative pole.

- Many clinician characteristics that lead to success in work have the potential to limit well-being.

- Burnout begins early, erodes the soul, and requires intentional intervention for prevention or recovery.

- Successful strategies for building and sustaining well-being include reframing experience, reflecting on experience, mindfully attending to work experiences, and honoring deeply held values.

- Building intimacy with friends and partners requires self-disclosure of feelings, dilemmas and conflicts.

- Professionals have a responsibility to foster the well-being of their friends and partners, colleagues and workplaces and even the planet earth.

---

**Learning goals:**

At completion of this module, you will be able to:

- Describe common clinician characteristics that may contribute to unhealthy personal beliefs, behaviors, and habits.

- Describe common causes and manifestations of professional burnout.

- Describe healthy cognitive, emotional, and behavioral practices that can promote your
well-being and sustain you throughout a career in medicine.

- Describe 3 changes in attitude, behavior or practice you could make that would improve or sustain your well-being.
- Disclose these changes and discuss their importance and potential barriers to their implementation with 2 important people in your life.
- Discuss why clinician well-being results in improved relationships and outcomes.

---

**THE LANDSCAPE: PERSONALITY AND STUDY**

In the first section of this module you'll find the following:

- **The Imposter syndrome: am I good enough?**
  Certain marker events in training—such as medical school graduation, becoming a senior resident, finishing residency, starting a first job—can lead to an inner expectation of competence that is not congruent with our own self-doubts.

- **Case: Jill, a medical student**
  Doing “only” moderately well while constantly studying and working feels inadequate when compared with carefree college days at the head of the class.

- **Compulsivity is a normal clinician trait**
  Clinician compulsivity, with characteristic doubts, guilt and an exaggerated sense of responsibility, produces benefits for patients, but if unbalanced, can produce fatigue, cynicism and isolation in us.

- **The “Hidden Curriculum”**
  The internal linking of exceptional performance and achievement with personal worth is a characteristic learned early by hard working people, and an impossible standard for medical students.

---

**The Imposter Syndrome: am I good enough?**

Certain marker events in training—such as medical school graduation, becoming a senior resident, finishing residency, starting a first job—can lead to an inner expectation of competence that is not congruent with our own self-doubts.

Many clinicians suffer from an “imposter syndrome” in the early stages of their career.

- They feel their outward appearance of competence is discrepant with their inner insecurity.
- They are concerned that they might be “unmasked” at any time.
- They keep their insecurity private, leading to a skewed perception that they lag behind their peers in competence.

---

**Case: Jill, a medical student**
Doing “only” moderately well while constantly studying and working feels inadequate when compared with carefree college days at the head of the class.

Jill Rayburn wondered if she would ever have fun again. She studied for her pathophysiology exam for a week, hadn’t slept in 30 hours and still felt ill prepared. She wondered whether she was cut out for medicine, in spite of being in the upper 20% of her class. Many classmates seemed unthreatened by the mountain of material to be mastered for this exam, and some had even gone for a hike yesterday. Last night Jill declined an invitation to play indoor soccer. She was beginning to resent the professor who invited her to co-author a paper, even though she felt flattered and honored to be singled out. Now she didn’t feel up to working on the paper, and wished she’d started preparing for this exam earlier. She remembered many carefree days in high school and college, when she was consistently at the top of her class. What had happened to that teenager with the sense of humor and time to hang out with friends? Looking ahead to that remainder of the winter, she saw no respite, only more deadlines and lonely days in the library.

Compulsivity is a normal clinician trait

Clinician compulsivity, with characteristic doubts, guilt and an exaggerated sense of responsibility, produces benefits for patients, but if unbalanced, can produce fatigue, cynicism and isolation in clinicians.

Compulsivity, with its beneficial attributes of thoroughness, accuracy, second guessing, and monitoring changes, is a common clinician habit. Compulsivity contributes to success in getting into medical school, completing training and high quality patient care. If not balanced through reflection and non-compulsive activities, however, this habit erodes clinicians’ well-being.

Jill manifests many aspects of compulsivity that can trigger cynicism and burnout by the time she is a resident. For example, she doubts her competence, in spite of evidence of excellent performance. She assesses her progress in reference to the perceived mastery of her peers, and in her fatigue cannot imagine attaining success in medicine. Jill will become dysfunctional if this neurotic thinking progresses into the “imposter syndrome,” in which she feels she somehow fools others into thinking she is competent, while the threat of being unmasked lurks at every turn. Additionally, Jill feels guilt about unwise allocation of her time, as no matter how hard she has worked, it does not seem to be enough. In addition to self-doubt and guilt, Jill also carries a burden of responsibility for meeting deadlines and obligations, and feels alone with that burden. She wonders about her peers’ enjoying an outing together and envisions her own continued isolation in the library. This triad of doubt, guilt, and an exaggerated sense of responsibility are well-described as constituents of the “normal” compulsivity trait in clinicians. (1)

In summary, the triad of compulsive behaviors that lead to overwork and burnout are the following:

- Doubt (“Maybe I missed something.”)
- Guilt (“No matter how hard I’ve worked, it’s not enough.”)
- Exaggerated sense of responsibility (“It’s all on my shoulders.”)

Compulsivity is one of the traits that can lead to a “psychology of postponement” that avoids honoring the important values and relationships in our lives. (2)

“Psychology of postponement”
Postponing relaxation, sleep and relationships begins early and can become habitual, and one consequence of this habit is that life may seem not worth living.

In the back of our minds we may have the nagging thought that this overwork is not good for us, that taking care of ourselves by getting enough sleep, exercise, eating well, having fun, and spending time with friends are all important; but in the “psychology of postponement”(2) we keep thinking, “As soon as this exam is over, then I can unwind.” The need to stay on top of our game, however, multiplies this bargaining with ourselves: “As soon as I get into the residency I want, then I can relax;” “as soon as I get accepted for a fellowship, then I can start working out;” “as soon as I start my first real job, then I can have a life.” Thus early in medical training a habit of postponement can develop that if unchecked can lead to neglecting many of our most valued relationships and activities throughout our career. Sir William Osler, in a commencement address to graduating medical students in 1889, had these words to say about postponement:

“Engrossed late and soon in professional cares...you may so lay waste that you may find, too late, with hearts given way, that there is no place in your habit-stricken souls for those gentler influences which make life worth living.”(3)

The “Hidden Curriculum”

The internal linking of exceptional performance and achievement with personal worth is a characteristic learned early by hard working people, and an impossible standard for medical students.

Jill’s torment has its roots in the early conditioning of many bright young people in American society, and medical schools exaggerate this characteristic as part of the “hidden curriculum.” We assimilated the message that our worth as persons is linked to academic success or outward performance. The need for love and acceptance is inherent in being human, and children who are repeatedly told they are valued only when they are “exceptional” link personal worth to meeting extraordinary standards. The achievement standard accompanies many students into medical school and collides with the reality that their peers are also top performers. They construe failure to stand out as failing to meet an essential marker of worthiness. We can choose to back off from overwork and carry the self-stigma of being “ordinary,” and unconsciously feel less lovable; or choose to work harder to stand out. Paradoxically, striving to “stand out” can lead to the very isolation and loneliness from which we are trying to escape.

The hidden curriculum also interacts with our need to conform to group norms. Our need to “fit in” mirrors the power of our drive to “stand out.” The new science of interpersonal neurobiology shows that we are wired to belong to groups; when we feel we belong brain opiate levels increase. Conversely the perception of being at risk for alienation from the group correlates with opiate decrements.4 This neurochemistry may produce “groupthink” and reluctance to question the group’s direction. If group norms tend to move us in ways that run counter to our values or diminish our health and well-being or that of others, it can require a heroic level of assertiveness to challenge them. (see “workplace health” et. seq., below)

Hidden curriculum effects - insidious and pervasive

Students and faculty are trapped by the effects of rewarding overwork.

Jill’s story also illustrates the insidious manner in which the system of medical education with its overt and covert rewards and punishments can reinforce inherent compulsivity. Her exceptional
performance was noticed by one of her professors, who asked her to co-author a paper. It is natural for teachers to ask top performers to do more, yet neither the teacher nor the student pauses to reflect on the potential toxicity of rewarding overwork. Medical school traditionally is good at channeling students into ever refined strata of academic and professional success, but not so good at mentoring them into building a career in which their professional endeavors unfold within a context of a healthy life well lived. Unless Jill were to encounter a mentor that has this broader grasp of personal and professional well-being, her role models and professors will continue unwittingly to provide a “hidden curriculum,” in which being a successful clinician entails putting one’s own life on hold.

Hidden curriculum makes capable students feel unworthy

The “hidden curriculum” in medicine teaches that success as a clinician entails suspending any effort to balance your own life.

- Not all worthy, capable students can be at the top of the class.
- The hidden curriculum insidiously leads students away from taking care of their own health.
- It promotes unhealthy behaviors that students may observe in faculty members and other role models.
- It encourages faculty and peers to reward overwork with acknowledgment and praise.

Some people successfully counteract the insidious effects of the hidden curriculum. Look toward faculty members and mentors who intentionally seek balance in their personal and professional lives to help you thwart these pressures.

Jill meets a mentor

Guidance from an experienced faculty member can counter effects of the hidden curriculum.

Dr. Ann Bennington, a teacher from a class on the medical interview, noticed Jill’s hunched posture and drawn facial expression. “Jill, you look like you have the weight of the world on your shoulders. How are you doing?” Jill managed a smile and protested, “I’m fine. I just finished the pathophys exam.” Ann confronted her mildly, “Well you look exhausted. When’s the last time you had an evening off?” When she noticed a tear forming, Ann replied, “Jill, I suspect you’re carrying more of a burden than you let on.” She suggested they meet that afternoon.

At the meeting in Dr. Bennington’s office, Jill slowly opened up with the self-doubt, emptiness, fatigue, and isolation she was feeling. Ann replied, “You know, Jill, you remind me of myself when I was a medical student.” Noticing Jill’s tears, she continued, “The fact that you are one of the brightest people in your class doesn’t seem to matter to you now. Like me you are a perfectionist, and one effect of that perfectionism is that we don’t feel we can get enough external validation for our worth. That’s because we weren’t taught to value ourselves from within, to know that we have immense worth before we ever set out to do great things.” She paused to observe Jill’s response. Since she was breathing more freely and seemed curious, Ann continued: “Striving for excellence is not wrong, and is in fact desirable. But what we mean by ‘excellence’ needs to be challenged. Your work will always occur within a real world context of the values you hold and commitments you make, as well as the limitations of time, personal energy, and competing tasks. Bumping up against these limits can be humbling, but ultimately accepting those limits and accepting your gifts will give you some freedom. Your body, mind and spirit are giving you feedback that you shouldn’t ignore. To the extent you can let your awareness of the origin of this pain lead you to greater self-acceptance, you will be an excellent clinician and a healing presence for others.”
Appreciating Versus Judging and Evaluating

The deleterious effects of “judgment” can be counterbalanced by cultivating “appreciation.”

- Judging and evaluating ourselves is a necessary component of improvement, but it can overwhelm appreciating ourselves.
- We are better at appreciating beauty in art and nature than we are at appreciating ourselves as persons.
- Building a habit of self-appreciation might include journaling about personal successes, allowing compliments to sink in, sharing our satisfactions with others, and cultivating present-moment, sensory awareness.

We are “becoming”, not yet “there”

Appreciating who we are instead of judging what we are not yet reminds us that we are “becoming.”

Among perspectives worth cultivating in the pursuit of well-being is the awareness that lack of perfection is an inherent part of the lengthy process of becoming a clinician. It is helpful to think of ourselves as “becoming” rather than insisting on holding an image of what we are not yet, and then unfavorably comparing ourselves to that image. The pressures inherent in medical training to continuously evaluate performance and judge one’s own competence are oppressive, and can be balanced through cultivation of the capacity for “appreciation.” When we respond to a sunset, to the first flower blooming in the garden in spring, or to the final movement of Beethoven’s 9th Symphony, this is typically not an act of judgment, but one of appreciation. We do not exercise the “judgment” and “appreciation” centers of our minds at the same time. An example of this tension was illustrated in a spiritual retreat. Participants on the retreat were asked to spend two hours one afternoon in silence, without books or other cognitive distractions, simply attending to what they observed through their senses. One clinician reported he spent two hours watching a caterpillar on the ground, wondering what led it to choose one direction over another. When the caterpillar arrived at a road, he debated with himself whether he should help it across the road or not. The group was moved by his story and shared their appreciation with him. In the post-retreat evaluation he wrote the following:

“I didn’t understand why it was such a big deal. But I started to think more about it—the feeling of wonder, suspension of judgment, trying to help but not being sure if I was being helpful. I’m good at feeling wonder about people and nature. I need to be better at feeling wonder and joy when pondering and observing me.”

Collaboration is an essential competency. Cultivate the practice of working cooperatively.

Clinicians are always part of a team working on behalf of their patients; whether in the hospital, the operating room or the office. Learning to collaborate as a member of a team counteracts an exaggerated sense of personal responsibility, and committing yourself to working cooperatively reduces isolation and mitigates the harmful effects of competitiveness on your health and well-being.
The competition to get into medical school and advance through training reinforces an exaggerated sense of personal responsibility. This attitude is too frequently carried forward into subsequent practice, in which the illusion is maintained that you are a self-sufficient professional, that asking for help is a sign of weakness, and that competency is distinguished by your ability to “go it alone.” Nothing could be further from the way health care is actually delivered. Systematic attempts to improve quality and reduce error demand that teams of professionals from various disciplines work cooperatively to provide patient care and promote the health of the community. The best medical schools are training for this, and the Accreditation Council of Graduate Medical Education (ACGME) states that “systems-based practice” and “professionalism,” which involve working as part of a team, are core competencies to be mastered during residency. Whether or not teamwork is reinforced by your medical school or residency, cultivating the practice of working cooperatively with others and committing yourself to helping colleagues succeed can contribute enormously to your personal and professional satisfaction.

**Reinforcing a maturing value structure**

A mentor guides through dialog and by example.

Jill’s encounters with Dr. Bennington, along with Ann’s willingness to discuss the importance of honoring life values, show that senior clinicians who have struggled to attain life wisdom can exert a powerful influence toward reversing the effects of the hidden curriculum. In choosing mentors, students would do well to seek out clinicians who tolerate the tension of keeping a balance in their personal and professional lives and explicitly honor and value family relationships, friendships, recreational pursuits, hobbies, and personal self-care.

In April of her 4th year of medical school Jill dropped by Dr. Bennington’s office. “How are you feeling about the match?” Ann asked. “Well, to tell you the truth,” Jill replied, “my initial first choice was a program where I could have pursued work based on that paper I co-authored. Since the match, however, I’ve thought more about the program I’m going to, and especially about one faculty member who interviewed me. I was struck by his family pictures, his children’s poems and drawings, and his sharing with me how much their training program valued both professionalism and the personal growth and life satisfaction of their residents.” “I’m glad I picked this program!”

Later, Jill sent Ann a note that read, “Thank you for reaching out to me at a critical moment, and helping me realize there was more to me than trying to be a star. You helped me value humility, which includes both appreciation of what I have to offer and acceptance of my limitations. You also gave me the great gift of realizing my own capacity for appreciating my life and for letting that be the ground from which to appreciate others.”

Dr. Bennington responded with a note that contained this poem by Derek Wolcott that you'll find on the next page.

**Love After Love**

By Derek Wolcott

The time will come
when, with elation
you will greet yourself arriving
at your own door, in your own mirror,
and each will smile at the other’s welcome,
and say, sit here. Eat.
You will love again
the stranger who was yourself.

Give wine. Give bread. Give back your heart
to itself, to the stranger who has loved you
all your life, whom you ignored
for another, who knows you by heart.
Take down the love letters from the bookshelf,
the photographs, the desperate notes,
peel your own image from the mirror.
Sit. Feast on your life.

THE LANDSCAPE: BURNOUT

“Burnout” results from chronic overwork, avoidance of renewing and energizing activities, and negative self-judgment.(5)

Burnout is a syndrome to which health care professionals are vulnerable. Burnout leads to impaired job performance, health problems, and chemical dependency. It includes the following components:

- Emotional exhaustion (compassion fatigue)
- Depersonalization (treating oneself and others as objects)
- Perceived clinical ineffectiveness (imposter syndrome)

Burnout can lead to dissociation, decontextualization, and cynicism.

- In dissociation, we withdraw attention from our emotions and somatic sensations, and we exclusively focus visually and cognitively on problem-solving and our “to-do” list.

- Decontextualization is the habit of thinking of others (and ourselves) in terms of their usefulness in getting our tasks done. They/we are abstracted from the full context of life, and become merely tools.

- Cynicism includes disillusionment about the ideals of service and altruism; our efforts are futile in the face of illness, death, human failures and meanness.

Case: Bill, a resident

Bill Trimmell trembled as he sat in the resident’s room wondering why he had raised his voice and scolded his last patient about not doing enough to monitor her blood sugars and for expecting him to keep her pain-free. Fortunately he had stifled the impulse to unload onto her that he had persistent back pain since a fall, and yet dragged himself to work to take care of whining patients like her. As he elaborated this imaginary conversation, he suddenly asked himself, “What am I doing?” This was only the second patient of the afternoon, and already he couldn’t wait to go home. His busy morning clinic included two walk-ins and one complex patient with lupus who was 10 minutes late and took an extra 20 minutes, putting him behind and leaving him 10 minutes to lunch on a stale bagel from the morning conference. He was only a third of the way through his second year of residency, and found himself resenting many of his patients and wondering what had happened to the altruistic dream of helping people that had led him into medical school. Why did he no longer care?
Mechanism

Burnout begins early in your career, and erodes your soul.

Dissociation from feelings, treating people as objects and feeling ineffective are the usual symptoms of burnout.

Bill has classical signs and symptoms of burnout, which consists of emotional exhaustion (including compassion fatigue and dissociation from feelings in general), depersonalization in relationships (treating oneself, patients, coworkers, and family members as objects), and a perceived clinical ineffectiveness. Burnout is described as “an erosion of the soul” that sends people into a downward spiral. Burnout may manifest as impaired job performance, sleep disturbance, irritability, marital difficulties, fatigue, anxiety, or depression. It can also be associated with poor health, including headaches, hypertension, myocardial infarction, and chemical dependency. The seeds of burnout are sown in medical school and residency training, where fatigue and emotional exhaustion are often the norm. In mid-career, the reinforcements in the work setting for being a hard worker and placing service to others before self-care maintain the momentum of this burgeoning condition. Recovery is difficult if one remains in the circumstances that generate the symptoms.

Cynicism

In the absence of thoughtful reflection with colleagues, clinicians develop cynicism about the futility of their efforts to help patients.

All too often clinicians are confronted with the reality of patients who are non-adherent to medical regimens, or who have chronic health problems that are refractory to all biomedical interventions. Unremitting exposure to cases in which their efforts appear futile leave clinicians feeling like Sisyphus, who endlessly rolled a large stone to the top of a hill, only to have it come tumbling down again. Without the opportunity to discuss these common experiences with peers and faculty, cynicism about patients and the effectiveness of patient care creeps in.

Compassion fatigue

Clinicians constantly in the presence of suffering may become unable to relate to themselves and others as individual persons with a full range of emotions and a unique life context.

The relentless parade of human suffering can run our emotional tank dry, an experience that is called “compassion fatigue.” If we focus cognitively and visually on complex patient care problems or get absorbed in our “to do” list in order to survive the days of suffering, dissociation occurs. We withdraw attention from our emotions and somatic sensations, become anesthetized to feelings and experience difficulty connecting with family and friends once we leave work. The cognitive correlate of dissociation is decontextualization. We develop a habit of thinking of others (and even ourselves) in a utilitarian way that abstracts and constructs persons into categories that have usefulness for our jobs and getting tasks done in a timely way. This strategy ignores the life contexts in which we and others are embedded. We commence relating to patients as diagnoses or appointments on the schedule, to coworkers as facilitating or impeding our work, to family and friends as intruding or placing unrealistic demands on our time, and to ourselves as task-processing machines. Ward residents view their work in terms of the tasks involved in admitting
and discharging patients, rather than in terms of the patient’s experience of illness. After several months observing what teams of ward residents did and what they communicated among themselves, one medical anthropologist concluded that the job of the ward resident is “getting rid of patients.”(6)

---

**Isolation**

**Personal isolation is common and fosters a sense of loss of meaning.** Community support and reflection can repair cynicism and restore meaning.

Carl Rogers once said that “what is most personal is most universal.” Nothing can be so personally isolating as the perception that one has lost one’s way professionally. It is reminiscent of Dante’s poignant lament at the opening of the Divine Comedy:

“In the middle of the road of my life I awoke in a dark wood where the true way was wholly lost.”

Nothing can be as healing and reassuring as discovering others who have traveled the same road and emerged as colleagues to admire and emulate. Retreats, support groups, and impromptu sharing of common experiences and struggles during lulls in the pace of work remind us that we are part of the human community and that we have the capacity for renewal and change.

Bill understandably feels a disconnect between his previous sense of vocation and the present sense of futility about the perceived ineffectiveness of his work. He finds himself slipping into disillusionment and cynicism. His job as a resident has begun to feel meaningless.

---

**Participate in Self-Care Activities**

Participate in peer support groups and programs for personal renewal in order to avoid or heal burnout problems.

- Attention to your self-care is an essential component of competency in professionalism.
- Sharing the challenges and stressors of professional life with colleagues reduces our suffering; “What is most personal is most universal.”
- Social supports contribute to well-being and buffer stress.
- Seek out or create programs that promote well-being throughout your professional life, such as the following:
  - Peer support groups
  - Well-being retreats
  - Journal clubs on professional balance and wellness

*In January of his second resident year, Bill attended a retreat offered by his program that focused on finding personal renewal in the work of caring for patients. In discussion, a senior resident shared that she had felt burned out and uncaring by the middle of her second year. Conversation led to the vulnerability of residents to burnout, and another resident disclosed that he was helped by observing a compassionate and patient faculty member at a dying patient’s bedside and then discussing how he remained centered during the encounter. The faculty member reported that keeping a journal of memorable events from the day gave him an opportunity to reflect on meaningful encounters in a way that the time pressures of work precluded. As the group talked, it became clear to Bill that he was not alone with this erosion of meaning and that there were*
personal and group strategies for renewing his enthusiasm for medicine.

STRATEGIES TO OVERCOME BARRIERS TO WELL-BEING

Cultivating Emotional Intelligence restores compassion and enjoyment and helps cope with the stress of feeling that our actions may be futile. With practice we can find ways to steadily renew our energy, at work as well as in other settings. Reflecting on the day’s or week’s events, perhaps by writing down our thoughts, builds capacity for mindfulness and the ability to be present to the meaning of our work and the gifts we constantly receive from it. We build additional resilience and further sustain a sense of well-being if we combine strategies.

- **The concept of Emotional Intelligence (E.I.)**
  The cultivation and expansion of our emotional intelligence can help restore our capacity for compassion and enjoyment of work.

- **The feeling of futility derives from thinking we can control outcomes.**
  Loosening the sense of close linkage between our actions and patient outcomes helps inoculate against discouragement and futility.

- **Sustaining vitality through steady renewal of energy.**
  Viewing work as a locus of “energy renewal” rather than “energy depletion” promotes sustainability.

- **Mindfulness brings the steady renewal concept into practice.**
  Intentional attention to our inner states facilitates renewal at work.

- **Regularly engaging in reflection promotes well-being.**
  Brief reflections increase our capacity for finding meaning in our lives. Simple strategies such as journal-keeping provide scaffolding from which we can derive and build well-being.

- **Resilience derives from combining well-being strategies.**
  Build resilience by combining well-being strategies, such as journaling, rituals, meditation, sharing uncomfortable feelings and stressors.

---

The concept of *Emotional Intelligence* (E.I.)

The cultivation and expansion of our emotional intelligence can help restore our capacity for compassion and enjoyment of work.(7)

Emotional intelligence includes the following components:

- Developing self-awareness
- Acquiring a language for emotions
- Controlling impulses
- Delaying gratification
- Regulating one’s moods
- Recognizing emotions in others
- Expressing empathy (Modules 6, 13)
- Cultivating assertiveness

People with high emotional intelligence regard emotions as facts, rather than problems to be
solved. They use their emotional intelligence to counteract dissociation and depersonalization. They discover that using components of emotional intelligence helps them develop connections with patients and colleagues.

Enhancing emotional intelligence improves relationships and teamwork

Noticing our emotions, naming them, disclosing them to another person, and discussing them develop our capacity for enjoyment and healthy relationships.

Among the strategies for restoring our capacity for compassion and enjoyment of our work is the cultivation of “emotional intelligence.” Developing the self-awareness component of emotional intelligence is a challenge for clinicians who are encouraged to dissociate from their feelings as a way of being “objective” in their professional role. Developing our self-awareness assists us in maximizing the quality of our relationships, which in turn is a major contributor to the therapeutic process as well as to personal well-being.

Emotional intelligence includes acquiring a language for emotions and enhancing our capacity for self-disclosure to others. The mirror of these aptitudes is the interest in recognizing emotions in other people, and the capability to do so. We can use our own emotions to develop hypotheses about what another person is feeling. We can learn to check out feelings with others, reflect feelings, comment on what we are observing, and receive the emotional disclosure of others without judgment. Development of these capacities seems entirely natural and instinctive for some learners, and foreign and difficult for others, depending on temperament, personality style and past experiences.

Assertiveness is central to authenticity in relationships

Being direct and authentic with others about what we think, feel, and want while tolerating their reactions and responses requires practice and intention. Valuing and employing this set of skills enables us to balance our needs with those of others and to build trusting relationships.

Assertiveness is an interpersonal skill— the skill of being direct with others about what we think, feel, and want in a calibrated way, without whining, shouting, eye-rolling, hostility or belittling, for example. Problems arise when we deviate from being direct, either through habitually devaluing our needs and feelings and subordinating ourselves or through seeking to impose our own will while devaluing others’ perspectives and interests. The need to “fit in” (above) can lead timid, self-effacing or “sub-assertive” people to hide their own viewpoints, feelings, and needs from scrutiny. They find it difficult to say “No,” become overloaded with responsibilities imposed by others and burn out.

On the contrary, the continuing need to “stand out” or meet extraordinary standards can lead some people to an overly assertive or aggressive stance. They are often unaware or intolerant of others’ feelings and needs. People who are aggressive in this way can allow their emotions to intrude on others, and can act out and become disruptive.

Assertiveness is the path of clarity, respect and the authenticity that is required for meaningful and productive connections with others.

Fostering emotional intelligence helps lead to a balancing of our own needs with those of others.
We can become more self-aware, can develop a vocabulary for our emotions, can state our truth while tolerating the emotional responses others may make to that truth, and can set clear limits to the intrusions or transgressions of others. That is, we can more clearly assess our own needs, and calibrate our verbal and non-verbal expressions. In medical education and clinical practice assertiveness is essential to building trusting relationships, to influencing others with integrity and to giving feedback. A resource with excellent suggestions on how to enhance assertiveness is Your Perfect Right. (8)

---

**The feeling of futility derives from thinking we can control outcomes**

Loosening the sense of close linkage between your actions and patient outcomes helps inoculate against discouragement and futility.

Bill’s feeling of futility in caring for patients who did not get better in spite of his best efforts emanated from his own beliefs and expectations about control. Gaining clarity about the extent to which control is possible in the events of our lives, and in the profession of medicine in particular, is essential to satisfaction with our work. Generally, people tend to be more satisfied when they perceive greater control over outcomes for which they have some responsibility. We indeed can have enormous influence within the array of factors that contribute to illness and health, but must recognize that most patient care outcomes are multi-determined and dependent on forces beyond our control, including patient choices, genetic and environmental variables and the work of other team members. A humble, yet realistic way of relating to work is to acknowledge that your actions are one significant influence among many other significant influences on the outcome of a situation. Think in terms of “influence” rather than “control”.

Releasing the need for treatment outcome to be a marker of competence can provide a helpful cognitive framework for self-assessment. The Zen philosophy of focusing on “right action” in the moment—whether it is the exercise of empathy, conducting a careful physical exam, engaging in clinical reasoning, or performing a procedure—is one way to relinquish this intense focus on positive outcomes.

---

**Additional coping strategies for feelings of futility**

Other cognitive tools that help inoculate against futility include the following:

- finding meaning in small victories, such as preventing a hospitalization for a patient with chronic emphysema
- using a recurrent worsening of a condition, such as a patient repeatedly admitted for diabetic ketoacidosis, as an opportunity to learn more about clinical medicine
- regarding “difficult patients” as visiting professors because of the learning opportunities they provide about how to manage complex interactions
- focusing on the quality of the relationship with the patient whose condition is worsening
- recalling the positive connections with grateful patients
- when your work is appreciated by others, taking time to reflect on the gifts that you have
Sustaining vitality through steady renewal of energy

Viewing work as a locus of “energy renewal” rather than “energy depletion” promotes sustainability. (9)

- An emphasis on the contrast between task accomplishment at work and relaxation away from work engenders rituals of doing and thinking that trap us and cause us to experience work as energy depletion.
- Instead, we can recharge at work if we emphasize the energy exchange that occurs between us and patients or team members during the unique encounters and activities that comprise a workday.
- This perspective emphasizes that each encounter contains seeds of renewal.

Looking at work as a locus of energy depletion is an unsustainable situation. Develop the ability to discover energy renewal in each moment, at work or elsewhere. In fact, competent clinical work includes a diversity of relationships which can and should bestow on us both inspiration and sustenance.

The notion of work as energy depletion is common to several unhealthy habits described above (compulsiveness, the psychology of postponement, dissociation from feelings, and tolerating conditions of burnout). Many clinicians view weekends, vacations, and time with family as the opportunity to recharge and recapture a more expansive awareness. Some seek to expand the time available for recharging by working part-time. The converse of protected “personal time” is the intense compression of “work time” and the density of tasks to be processed in a given day. An altered state of consciousness may emerge during the surreal pursuit of the processing of tasks in which “productivity” is equated with “being good.” Clinicians enter this trance in the presence of certain ritualistic cues (the door to the office, turning on the computer, checking the schedule, retrieving voice mails), and other effects of this state may include running an incessant “to do” list, looking for brief tasks to process in an illusory pursuit of “closure,” a shortened attention span, irritability in the presence of lengthy or labored conversations, a habit of checking and rechecking one’s work, stewing about difficult interactions in the past, and worrying about future events.

Steve McPhee, a professor of medicine at UCSF, contrasts solar-powered and gasoline-powered automobiles in thinking about energy in our daily lives. (9) The notion of work as a locus of energy depletion (requiring a leaving of work to find energy renewal) is similar to the dependence of industrial societies on non-renewable fossil fuels. When a solar car uses energy, it opens panels that simultaneously draw energy from the sun. The fossil fuel model represents a view of oneself as an individual source of productivity and accomplishment, acting with agency upon the material world and upon people’s lives to achieve outcomes. The solar car model suggests a view of oneself as a medium of energy exchange, a self-organizing system much like a candle flame that gives off light in the process of continuous transformation, a system that is embedded within, and a part of, larger self-organizing systems such as a doctor-patient relationship, a healthcare system, a society, the earth itself. (10)

Mindfulness brings the steady renewal concept into practice

Intentional attention to our inner states facilitates renewal at work.
Our stream of consciousness typically includes thoughts about the past, sometimes accompanied by regret or resentment, and thoughts and images of the future, sometimes threatening, sometimes escapist. The “productivity trance” (above) drives us to run our “to-do” lists as an incessant background refrain. What is the psychological equivalent of “opening our solar panels,” to prepare ourselves for renewal as we move through our days, both at work and at home? One straightforward approach is **mindfulness**, the discipline of living an intentional, conscious life. Mindfulness is a counterweight to enchantment with the “there and then,” and increases our capacity to be present in the “here and now.” Mindfulness involves non-judgmental attention to our emotional and mental states as they pass through awareness.

Mindfulness is on the one hand simple, and on the other hand requires practice to become proficient, as with any skill. (11-18) Becoming mindful imparts many benefits, and might be considered an important component of professionalism. We can be present to patients without contamination from what happens before or after that encounter. (16-17) We see ourselves as vessels through which the various feelings of joy, sorrow, anger, affection, peace and agitation flow, but these feelings do not define who we are in any moment of intensity. Mindfulness is then the gateway to accessing opportunities for personal renewal in the midst of work, if we intentionally attend to receiving energy from personal interactions or the satisfaction of work well done. (19)

---

**Aspects of mindfulness**

**Mindfulness** is a practice and a gateway that opens opportunities for self-renewal as we move through the day.(11-18)

Mindfulness is the practice and habit of being present to where we are and what we’re doing. This skill of “being present” requires practice to become fully cultivated and developed into a habit. The investment in acquiring this skill reaps dividends in enhanced relationships and personal balance. A group of primary care clinicians who underwent intensive training in mindfulness showed significant improvements in non-judgmental attention to the present moment, reduction in burnout and mood disturbance, increased empathy toward patients, and improvement in personality factors of conscientiousness and emotional stability. These changes endured several months after completion of the training.(18) Rituals may be as simple as a conscious pause before entering a patient’s room. We can also use recurrent contextual cues (such as each time we cross a threshold from one room to another) as reminders to pause, attend to our breath, and refocus our sensory awareness on the event into which we entering. Mindfulness helps us to attend without judgment, and to not let single encounters, thoughts, or events define who we are.

(module 2)

---

**“Being Human is a Guest House”**

Attention to the daily surprises at work and in our inner lives can guide us toward well-being.

The process of approaching each day with mindfulness and openness to the uncertainty of who will walk in the door next, and non-judgmental attention to the “weather” of our own emotions and those of others, is captured in this poem by Rumi, the 13th century Sufi mystic whose verses reach across the centuries and cultures to speak to our own experience (20):

**The Guest House**

This being human is a guest house.
Every morning a new arrival.
A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor.

Welcome and entertain them all! Even if they’re a crowd of sorrows, who violently sweep your house empty of its furniture, still, treat each guest honorably. He may be clearing you out for some new delight.

The dark thought, the shame, the malice, meet them at the door laughing, and invite them in.

Be grateful for whoever comes, because each has been sent as a guide from beyond.

**Regularly engaging in reflection promotes well-being**

Brief reflections increase our capacity for finding meaning in our lives. Simple strategies such as journal-keeping provide scaffolding upon which we can build well-being.

If we incorporate a moment of reflection at the end of each day, we gradually become conditioned to perceive the opportunities for personal renewal and meaning contained in various encounters of the day. Using a journal or just pausing to reflect back for five to ten minutes on the events of the day can offer a transitional time to absorb the gifts that came our way, and let go of the day. Angeles Arrien suggests that we ask three simple questions: “What surprised me today? What moved me today? What inspired me today?” Sometimes we discover important personal meaning in our encounters with the full panoply of human experience, including suffering.

Another option would be to keep a “gratitude journal” at the end of each week. Write down a few things for which you are thankful, from simple events like watching a particularly beautiful sunrise to more profound ones like a satisfying encounter with a patient with whom you had a previous troubling relationship. Building in reflective time increases our attentiveness to meaningful moments as they occur, and renews vitality.

**Resilience derives from combining well-being strategies**

Build resilience by combining well-being strategies, such as journaling, rituals, meditation, sharing uncomfortable feelings and stressors.

*In the weeks following his retreat, Bill experimented with briefly making daily journal entries. He began to notice sources of energy boost—a joke shared with nurses, the satisfaction of being compassionately present to a patient’s distress, learning a new diagnostic algorithm for certain illnesses, guiding an intern in managing a complex admission, observing a faculty preceptor facilitate a difficult family meeting about end-of-life care. Bill started an introductory book on*
mindfulness meditation and was sometimes able to take 5 minutes to practice meditation before his day began. Some days were incredibly busy, and he was still confronted with uncertain medical dilemmas and difficult patients, but he seemed to take it more in stride. He more frequently centered himself before walking into the patient’s room by taking a couple of breaths and letting go of what went before, while embracing the unknown of the encounter awaiting him. Bill enjoyed the comradeship of his fellow residents and more often shared stresses and uncertainties. He felt more grounded, less isolated and experienced his work as more meaningful.

PROFESSIONAL WORK, INTIMACY AND FRIENDSHIP

Demands of professional work conflict with the rest of life, and learning to honor deeply held values by distinguishing between the urgency and importance of a demand helps to balance your life.

Regularly engaging with friends and building intimacy through the sharing of dilemmas and conflict builds intimacy. Successfully coping with the stresses of long-term intimate partnerships, including managing feelings about money, further sustains well-being.

Subordinating relationships to work demands can erode relationships. Professional responsibilities collide with relationship needs and personal commitments. On any given day it might make sense to let work demands take priority. Cumulatively, however, repeated instances of subordinating personal values leads to erosion of cherished relationships and to neglect of vital parts of our lives.

Case: Lisa’s family conflict

Lisa Logan tried hard to keep on schedule in order to get to her daughter Megan’s soccer game at 5:00, and was nearing the end of seeing her own patients and precepting residents. This was 6-year-old Megan’s first game of the season, and this commitment was of special importance to Lisa because last month she was an inpatient attending and had seen very little of her two children. Roger, age 4, complained to Lisa’s husband David that he “hardly saw Mommy any more.” This was Lisa’s fifth year on the residency program faculty, and she had hoped that by now her routine would be more balanced.

Throughout residency David, an attorney whom she married at the end of medical school, was understanding and tolerant of her late nights and often irregular rotations. Lisa took maternity leave during her second year of residency, but it seemed all too short and she felt she missed many of Megan’s developmental milestones. She regretted that David had to cancel their last anniversary dinner reservation because she was managing a difficult patient’s admission. They did have a pleasant evening out the following night, but it was not the same for her. Earlier today David called to say he might miss Megan’s game, since the case he had hoped to settle was going to trial. Since Megan had a ride to the game with her friend’s mother, could Lisa meet her there? Lisa was on track when her last patient, who had been trying to get in for two weeks because of intermittent dizziness and headaches, called. Mrs. Albright had a flat tire, and would be a half hour late. If Lisa stayed to see Mrs. Albright, who had been waiting two weeks to see her, she would miss most of Megan’s game.

For the Goddess of Love
The “psychology of postponement” mentioned above finds poignant expression in this poem by Rabindranath Tagore (23):

**For the Goddess of Love**

There is a ruined temple near here....No one sings now for the Holy One who was once praised there. The air is motionless and heavy above the altar.
The odor of flowers no long pulled for you floats in through the door.

One of your old worshippers goes out every day into the cities, hoping to receive the good things that he used to ask for from you. And every day at dusk he returns five thousand miles to his temple, his shoelaces untied, his face tired.

How many good days go by! How many nights useful for worship go by, and not one candle is lit or one poem sung!

How many sculptors work the whole day with large shoulders and hair whitened with stone dust making a statue of you, and then as dusk comes carry it to the river and throw it in.

She is still in the temple, but no one gives Her food or takes food from Her, in this ignorance that never ends.

---

**Honoring deeply held values: urgency versus importance**

How we spend time and energy everyday manifests our value hierarchy, and taking a close look at both the urgency and the importance of what we do may reveal that our actions fail to honor what we thought were our deeply held values.

Steven Covey, in *The Seven Habits of Highly Effective People,* suggests that we compare the *urgency* of a demand or a potential activity with its *importance* in our value hierarchy, before we act. To compare, we can construct a 2 X 2 matrix with four quadrants:

<table>
<thead>
<tr>
<th>IMPORTANT</th>
<th>NON IMPORTANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>URGENT</td>
<td>III</td>
</tr>
<tr>
<td>NON URGENT</td>
<td>IV</td>
</tr>
</tbody>
</table>

Actions in **Quadrant I are both important and urgent**, and we neglect them at great peril; examples might include an ICU patient who is crashing, a sick family member, and completing tax returns on April 14. **Quadrant III is the area of deception**, where things take on the illusion of importance because of the noise of urgency. Failure to discriminate between I and III forces us to overload by responding to emails, voicemails, meetings, and interruptions that can overwhelm our carrying capacity. Most overloaded people escape into **Quadrant IV, the area of waste**, where we might mindlessly watch T.V., read cereal boxes, surf the internet, or aimlessly rummage through old files. **Quadrant II is where we honor our deepest human values**, nurture relationships with intimate partners and family, mentor others, continue our professional education, engage in strategic planning, attend to our own health needs, do volunteer work for the betterment of our communities, enhance our artistic abilities, and grow spiritually.

Because many people view Quadrant II activities as “non-productive” and we value their approval, we may move to Quadrant III, carrying both the illusion of productivity and the appearance of busyness. Because of the intensity and even enchantment of the culture’s “productivity trance,” our challenge is to discern which values belong in Quadrant II and regularly schedule time to
honor them.

Sharing your personhood by disclosing dilemmas invites support

Patients and colleagues respond positively and support professionals who appropriately show their humanity by sharing their conflicts, dilemmas and values, even indirectly.

Megan’s soccer game was already on Lisa’s schedule, but she now faced a choice between important values—her patient responsibility and her commitment to her daughter. In some cases the burden of choosing can be shared ahead of time with patients, colleagues and family. To the extent that we can selectively disclose to patients those aspects of our personal lives that we are comfortable sharing—even indirectly by displaying photos of family members, pets or mountains we have climbed—we give ourselves permission to disclose a conflict when it occurs. Likewise we can share with family members the dilemmas that inevitably arise in caring for sick patients. Sharing with colleagues frequently brings mutual support for struggles to balance our personal and professional lives, and we become better able to help each other resolve conflicts.

Lisa shared her dilemma about Megan with a colleague, Jim. From previous discussions Lisa knew that Jim held similar values about balancing work and home life, and she had covered for Jim during his father’s illness. She asked if he could see Mrs. Albright for her. Jim agreed, and Lisa asked her nurse to assure Mrs. Albright that she would confer with Jim and telephone her tomorrow. Lisa felt confirmed in her decision when she saw Megan smile and wave as her team walked onto the field.

Build intimacy with friends, partners and family

In relationships outside of medicine we discover our potential as persons. The burden of constantly receiving patients’ confidences can inhibit our capacity for self-disclosure and intimacy. In order to deepen friendships we must foster this capacity and be intentional about seeking time and settings to enrich these relationships.

Clinicians expend considerable time with patients and steadily receive their confidences and disclosures, but may have less familiarity with self-disclosure to friends, or time to engage with them in this intimate way. A fear of intimacy or lack of interest or skill in sharing our inner selves with others sometimes adds to the challenge of nurturing our relationships that is posed by professional demands.

Opportunities for forming friendships abound in the work setting, if we take the initiative to engage with potential friends. In relationship with others we deepen our identity and discover our potential as persons. Most clinicians develop hobbies and interests outside of medicine in the arts, volunteer work, political action, a faith community, sports, or outdoor activities. However, being with friends without developing our capacity for self-disclosure is insufficient. Learning to confide in trusted friends is an essential counterbalance to constantly receiving the confidences of patients in our professional roles.

Long-term intimate partnerships

Because of the “psychology of postponement,” (2) building, sustaining and benefiting from an
enduring relationship with an intimate partner requires enhancing our communication skills, learning to tolerate differences, clarifying values, and negotiating issues such as time, sex, money, and the raising of children.

A long-term journey with an intimate partner is a cauldron which both tests our identity and expands our capacity to embrace life and endure its stresses and challenges. An extended love relationship can be a great spiritual path to our growth and development as persons. In such a relationship we can learn acceptance of ourselves with all our flaws and virtues, as well as learn the art of compassion through nurturing our beloved and seeking their well-being. Enhancing our interpersonal communication skills--especially the art of active listening, disclosure of feelings, and negotiating respectfully when there are differences and conflict--is central to an enduring relationship.

To build and sustain a loving partnership requires scheduled Quadrant II time. Other key ingredients include awareness of our family of origin influences on intimate communication and expectations; learning to tolerate differences in tastes and preferences; clarifying mutual values as a couple; and negotiating time, sex, money, space, division of labor, and whether and how to raise children. Romance and sex occur spontaneously early on, but will later require intentional planning to create the time and conditions for this vital component of relationship to ripen into a lasting source of mutual renewal. When intimate relationships stagnate or communication patterns do not feel loving and compassionate, couples counseling can be a valuable resource.

---

**Money versus other values**

Clarifying our relationship to money is essential to realizing our life values in a culture that is enchanted with the accumulation of wealth. Our core philosophy about money, debt and wealth can turn the flow of money through our lives into a burden or a useful tool.

Concern about money too often displaces the time required to honor personal values and relationships. Trepidation about paying off educational debts may lead to working longer hours or moonlighting, which diminishes time and energy for family, friends, and hobbies. Sometimes material aspirations lead us to encumber more debt than necessary and we trade Quadrant II time for money, inevitably a dehumanizing exchange. One clinician couple who realized they were “sacrificing precious time and earning money to support a lifestyle not worth living”(28) engaged in value clarification and financial assessment that led to downsizing material possessions, eliminating debt, and embracing a path of “voluntary simplicity.”(29) Engaging in clarifying life values and financial goals in consultation with a financial planner or through the self-help literature (25-27) can provide a framework for wise decisions about money, income and life.

---

**Additional well-being components**

Spiritual or religious practice, volunteer service and time in nature are known to contribute to personal well-being (30), and we describe some aspects of these parameters in this section.

- **Spiritual or Religious Practice**
  Involvement in a spiritual or religious practice is often a component of human happiness, according to growing evidence. Spirituality typically entails a belief system that views oneself as part of a larger whole and can involve emotional experiences of awe at the transcendent dimensions of life. This part-whole relationship gives a sense of narrative meaning to life, in which one’s own story is seen as a part of a larger unfolding story. Spiritual experience may or may not entail belief in a divinity or supreme being. The sense of the larger story can provide guidance for moral decisions. Spirituality is not synonymous
with religion, but may find expression through the rituals and community practices of a specific religion. If one comes from a particular religious background, it can be helpful to understand the influence it played in one’s family of origin and one’s own life. Reading widely about the great wisdom traditions and engaging in dialogue about them can deepen understanding of humanity and inform life choices about spiritual practice.(31)

- **Volunteer Service**
  Mounting evidence on the health effects of volunteering shows that those who donate time and energy in service to others are healthier, live longer, and experience greater well-being than those who do not. One study found that volunteers had higher life satisfaction, a stronger will to live, greater feelings of self-respect, and fewer depression and anxiety symptoms than non-volunteers. Volunteering may enhance mental health for several reasons. First, it is a form of social participation that buffers stress and is correlated with mental health. Second, volunteer work is a helping behavior that has intrinsic value and meaning. Third, it gives us a sense that we make a difference, thereby increasing self-efficacy. During medical training, discretionary time for volunteer work is limited, but donating even two hours a month in any setting can establish a life value that carries over into one’s professional career. Among abundant opportunities open to clinicians are social service agencies, international relief organizations, environmental protection, and political advocacy.(32)

- **Time in Nature**
  Contact with the wildness of nature—whether tending a garden or hiking through the back country—reminds us that we are that part of the earth that has become conscious of itself. Some biologists believe we are wired to respond with inner calmness to the natural world, possibly through activation of the parasympathetic nervous system.(34-35) Scott Momaday, Pulitzer Prize winning author of *House Made of Dawn*, put it this way, “…once in our lives we ought to concentrate our mind upon the remembered earth. We ought to give ourselves up to a particular landscape in our experience; to look at it from as many angles as we can, to wonder upon it, to dwell upon it. We ought to imagine that we touch it with our hands at every season and listen to the sounds that are made upon it. We ought to imagine the creatures there and all the faintest motions of the wind. We ought to recollect the glare of the moon and the colors of the dawn and dusk.” (33) We can expand our well-being through periodic excursions into wildness and by carrying memories or photos of these experiences into our daily lives.

---

**WORKPLACE HEALTH AND PERSONAL WELL-BEING**

Personal commitment is necessary but not sufficient to sustain well-being. Professionals must accept the responsibility of developing model workplaces that support staff well-being. Healthy staff produce better results, such as higher quality, fewer errors and high efficiency, which in turn support the organization.

- **Workplace challenges to Personal well-being**
  Toxic workplace structures and demands challenge our personal commitments.

- **Model workplace environments exist**
  Certain groups have successfully accomplished workplace change. Making institutional change is always a collective enterprise, and we will create healthy work environments only to the extent that we collaborate.

- **Healthy workplaces are more likely to be sustainable and profitable**
  Organizational health and clinician and worker well-being are mutually reinforcing.
Workplace challenges to personal well-being

Toxic workplace structures and demands challenge our personal commitments.

Well-being is not only an individual process, but a political process as well. For our own well-being we might accept the challenge of behavior change, and begin, reinvigorate or enlarge activities that we discussed in the preceding sections, such as any of the following:

- spiritual practice
- physical activity or an exercise program
- cultivation of hobbies
- connecting with nature
- creative expression in arts or writing
- volunteer service
- eating properly and getting adequate sleep
- practice of mindfulness or meditation
- enhancement of our intimate relationships

Unfortunately, these well-intentioned efforts to balance our lives may evaporate at the next staff meeting, where overwork is reinforced and rewarded with admiration, the esteem of colleagues and the imperatives of meeting productivity expectations. Workaholic colleagues are often rewarded with greater influence. Both in school and at work the “hidden curriculum” supports unrealistic ideals of tireless clinicians always available to others.

For the well-being of health professionals to thrive, our workplaces must value the health and well-being of all their workers. Each of us has a responsibility to engage in the difficult work of changing our organizations—medical schools, residencies, health care systems and practice settings—so that they allow time and energy for the persons who comprise the profession to develop and sustain well-being activities and a sense of professionalism.

Model workplace environments exist

Certain groups have successfully accomplished workplace change. Making institutional change is always a collective enterprise, and we will create healthy work environments only to the extent that we collaborate.

Some health care organizations have developed work environments and policies that honor the values and health of their clinicians. A group of neonatologists in Oregon developed a flexible system that allows each clinician to select the amount and distribution and type of work twice a year. They can reduce workload to pursue non-medical endeavors, or increase it to meet economic needs. They evolved a consensus building and dialogue process to confront the challenges of promoting balanced lives.(36) Indiana University School of Medicine is confronting the “hidden curriculum” and fostering a social environment that consistently embodies and reinforces values of personal and professional growth, connectedness, passion, and wonder.(37)

Healthy workplaces are more likely to be sustainable and profitable

Organizational health and clinician and worker well-being are mutually reinforcing. Health care organizations that promote the well-being of their employees and staff discover that satisfied
workers produce many benefits for the organization.

These benefits include, but are not limited to, the following:

- increased patient satisfaction and lower subscriber turnover
- better recruitment and retention of clinicians
- enhanced productivity
- diminished employee impairment from stress-related factors
- improved patient safety and reduced errors
- optimized efficiency from better communication that diminishes resource utilization (such as tests, referrals) (38, 39)

The Great Wave of Kanagawa

Katsushika painted chaotic waves, sailors collaborating to keep their boats upright, and Mt. Fuji, fully anchored to the earth. The painting might be taken to represent certain elements of personal and organizational well-being that were recognized as important many centuries ago, as they are today.

This painting, The Great Wave of Kanagawa, by the artist Hokusai Katsushika, is from a series entitled "36 Views of Mt. Fuji." It captures several of the elements of personal and organizational well-being discussed above. The first and most obvious element is the waves, which are relentlessly chaotic and threaten the balance of the boats. The waves call to mind the ongoing challenges and uncertainty of clinical practice. The second element are the people in the boats, who require cohesion, teamwork, and ongoing communication to keep the boats headed into the
waves and moving successfully forward on their journey. A healthy organization provides such a disciplined collaboration for its members, so that no one person bears the sole burden of responsibility. The third element is Mt. Fuji, at first indistinguishable from the waves, which in its deeply grounded stability provides the still point in the center around which the chaos revolves. Mindfulness and self-awareness can provide such a stillness within which we can rest at the deepest center of ourselves as we continue to adjust our balance to catch the next wave.

**PLANETARY SUSTAINABILITY AND PERSONAL SUSTAINABILITY**

Being mindful of factors that promote environmental and planetary health by increasing carrying capacity or decreasing the load from human activity furnishes us insights into the sustainability of our lives and careers.

Finally, the health and well-being of our personal lives and of the organizations within which we work is embedded within the health of our planet. Land use planners, when determining where human population growth in a region should be allowed to occur, employ the following equation: $C - L = M$ (Capacity - Load = Margin). Here capacity refers to the “carrying capacity” of the land (available natural resources, transportation corridors, and ability to absorb the wastes of human activity.) Load refers to the impact or “ecological footprint” of that human activity upon the land. (40) When the carrying capacity of the natural environment is greater than the additional load of human activity, there will be a positive margin and population growth is sustainable. Conversely, when load exceeds capacity, there is a negative margin and growth is unsustainable. On a global scale this same equation applies.

This same equation, $C - L = M$, might be applied to our own lives and the organizations within which we work. When our capacity as persons is chronically overloaded by work, family, and other commitments, then we are in a negative margin that is unsustainable, heading for burnout. It is as if we are drawing down the principal of our resources rather than living off the interest. Conversely, when our capacity routinely exceeds the load we assume, then our lives are sustainable.(41)

**CONCLUSION**

Because we are that part of the earth that is conscious of itself, our “great work” is to restore the proper relationship of humans with the earth. Our lives of service to patients and colleagues are not sustainable unless we develop attitudes and skills that support our well-being. Because we are health professionals, we should also expand capacity through teamwork and enhancements to the health of our organizations and their workers.

Sustaining a life as a professional and as a person in this complex, information-rich and choice-rich era necessitates new skills that were not required of previous generations. However, renewing and balancing our lives entails drawing upon the “practical wisdom” of previous generations. This practical wisdom, what Aristotle called *phronesis*, incorporates the cognitive, emotional, behavioral, and interpersonal skills to expand our capacity as persons and reduce or eliminate the non-important and unnecessary loads that erode our spirits. Because we work within healthcare systems, we also are compelled to develop a practical wisdom that promotes workplace sustainability, such as expanding our capacity through teamwork, clarifying the organization’s values, and establishing structures and processes that enhance the well-being of healthcare workers. Finally, we must awaken to the full context of our lives, knowing that we are that part of
the earth that has become conscious of itself. Restoring the proper relationship of humans with the earth in a way that promotes sustainability in the whole system is what Thomas Berry has called “the great work” of our generation. Developing the practical wisdom to engage in this work in a sustainable way is every clinician’s personal and collective challenge.

BEHAVIOR CHECKLIST

We hope that you will pause to discern what you could do to foster your own well-being in the coming days, weeks, months and years. For your convenience, we list well-being oriented behaviors and activities discussed in this module.

- Seek out mentors who strive for balance in their personal and professional lives.
- Build habits of self-appreciation
  - Keep a journal of meaningful moments.
  - Take time to allow compliments to sink in.
  - Share satisfactions and successes with others.
  - Keep a “gratitude journal.”
- Cultivate your capacity and skills for working in a team.
- Learn the skills of negotiating and resolving conflict in a respectful fashion.
- Consider emotions (your own and others’) as information.
- Develop a language for your emotions.
- Disclose your feelings to significant persons in your life.
- Learn to recognize emotions in others.
- Learn the skills of empathy.
- Develop your capacity for intimacy.
- Develop intimate partner communication skills.
- Learn and implement the practice of mindfulness.
- Focus on right action instead of outcomes. (Replace pursuit of “control” with realistic awareness of your “influence.”)
- Look for opportunities for renewal in the midst of work.
- Engage in reflection on meaningful moments at the end of the day.
- Keep a journal on meaningful moments from the day.
- Use the Important/Urgent matrix to review how you spend your time.
- Schedule time for the important activities in your life.
- Cultivate friendships both in and out of work.
- Participate in a peer support group.
- Read and discuss literature on professional well-being.
- Engage in physical exercise.
- Develop a hobby.
- Develop a spiritual practice.
- Practice good sleep hygiene.
- Connect with nature.
- Engage in volunteer community service.
- Clarify your financial goals.
- Engage in personal, couple or family psychotherapy.

LITERATURE REFERENCES

2. Gabbard GO, Menninger RW. The psychology of postponement in the medical marriage. JAMA 1989;261:2378-81
3. Spickard A, Gabbe SG, Christensen JF. Mid-career burnout in generalist and specialist clinicians. JAMA 2002;288:1447-1450
18. Frankl V. Man’s Search for Meaning. Simon & Schuster, New York, 1984
23. New Road Map Foundation www.newroadmap.org

loading..
Welcome to DocCom Module 05:
Integrated Patient-centered and Doctor-centered Interviewing

by Auguste H. Fortin VI, MD, MPH, Francesca Dwamena, MD ; and Robert C. Smith, MD, ScM

© 2005-2014 by AACH, Drexel University College of Medicine and others

Credits:
Authors: Auguste H. Fortin VI, MD, MPH; Francesca C. Dwamena, MD; and Robert C. Smith, MD, ScM
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Standardized Patient: Mike Onori
Clinician on camera: Auguste H. Fortin VI, MD, MPH
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History: 3.0 - 12/8/2011 (HTML5 and MP4 enhanced)
2.0 - 7/7/2009 (upgrade to DocCom version 4.0)
1.0 - 6/27/05

VIDEO (not shown in print-out text)

Rationale
Questions for Reflection:

- Many beginning students are so anxious about “getting the interview right” that they have trouble listening to the patient. What strategies can you use to listen attentively?
- How do you feel about asking patients about their personal lives and emotions?
- How do you feel about becoming a therapeutic agent by the way you interview patients — how personally involved with patients do you want to be as a clinician?
- What will you do if a patient cries?

Key Principles:

- Caring for patients means seeking to understand their illness stories in the context of their lives, and the interplay of biological, psychological, and social factors that promote illness in individual patients. This understanding will guide your diagnostic and therapeutic efforts, and patients will reward your search for understanding with trust and gratitude.
- Integrated patient-centered and doctor-centered interviewing (a process) produces the biopsychosocial data (the content) that enables us to make a full diagnosis and effectively treat the patient.
- By learning and practicing basic interviewing skills, you develop facility at eliciting a complete and accurate medical history.
- Improving your skills and your compassion in an infinite variety of situations is a lifelong process

Learning goals:

At completion of this module, you will be able to:

- describe the content, and process of a “complete” medical history,
- describe the difference between the tasks or functions of an interview and its structure,
- describe patient-centered and doctor-centered interview goals and skills,
- describe the different contributions of patient-centered and doctor-centered skills to understanding the patient’s full (biopsychosocial) history,
- describe the content and structure the written medical history.
In this module we introduce the medical interview and review important background concepts. We describe the process of obtaining and communicating a complete history through integration of doctor-centered and patient-centered approaches to obtaining information, and then synthesizing the information into a standard “write-up” of the medical history.

As you embark on learning and/or improving skills of interviewing, you will find it helpful to review this list of concepts, each of which is discussed later in the text that follows.

- the biopsychosocial model
- the differences between disease and illness
- the concepts of curing and healing
- the science and art of medicine
- the goals of medical interviewing
- the tasks, functions and skills of medical interviewing
- doctor-centered and patient-centered approaches to interviewing

---

**Biomedical model and biopsychosocial model**

With the remarkable ascendance of biotechnology, the practice of medicine is increasingly biomedically oriented. The “biomedical model” assumes that disease is related to pathophysiology and can be understood and effectively treated within the realm of biology. George Engel crystallized an alternative way of understanding illness when he articulated the “biopsychosocial model”. (1)

This model assumes that human health and illness depends not only on factors in the biological sphere, but also derives from factors in the psychological and social spheres of a patient's life. A disturbance in any sphere can affect the illness process. When you understand how these multiple factors interact in patients' illnesses, you can design and recommend more effective therapies.

---

**Disease and illness, curing and healing**

Disease implies a disruption in normal biologic function. Disease is objective: you can see disease processes under a microscope and in abnormal laboratory tests. Illness is subjective: people feel a sense of dis-ease; they identify themselves as sick; they behave in different ways than when they are healthy; they seek medical care.

A patient can have disease without illness, as in a breast cancer that hasn't yet been discovered; and illness without disease, as in hypochondria. Most patients who seek medical care have *both* disease and illness, in varying degrees. Some stoic patients can have serious disease but little illness behavior, while other more demonstrative patients may have little biologic disease and be incapacitated. These are important distinctions relevant to daily clinical work, since patients come to clinicians with their illnesses seeking biologic cure, and clinicians are eager to find and treat the disease. The distinctions of curing and healing now become clearer: we cure diseases with
Medications, surgery and biotechnology. We heal illnesses mainly through our words. All clinicians must be able to combine their healing and their curing.

The science and art of medicine

Medicine is a scientific discipline, and it depends on other scientific disciplines such as anatomy, physiology and pathology, as well as psychology, sociology and other behavioral sciences.

We can understand much of patients’ diseases and illnesses through the knowledge and skills we have attained in these disciplines. But medicine is also an art: health outcomes depend on the unique, intimate relationship between clinician and patient. Clinicians use themselves as instruments of diagnosis and therapy. Your unique blend of knowledge, skills, attitudes, personal history, emotions and personality will have an effect in your relationships with patients. Your use of yourself in shaping patient care is what comprises your unique contribution to the art of medicine. For that reason, you must care for yourself and seek self-awareness so that you can use yourself wisely to the benefit of your patients. (modules 3, 4)

The goals of medical interviewing

You seek to accomplish several goals when you interview a patient. You elicit the information you need to make a diagnosis of a patient's disease. You achieve an understanding of the nature of the patient's illness and how it relates to underlying disease processes. You establish rapport.

This rapport engenders trust, which enables patients to reveal critical personal information. A trusting relationship is the foundation for effective patient education and counseling. By the end of an interview, you should have a good idea of the differential diagnosis, a sense of why the patient is ill now as opposed to some other time, and of the attitudinal, social and behavioral factors that contribute to the onset and maintenance of illness.

The Tasks, Functions and Skills of Medical Interviewing

Seventy-five to 95 percent of the information needed for clinicians to make a correct diagnosis comes from the patient-reported medical history (2,3). The quality and quantity of diagnostic information gathered in the medical interview depends on your interviewing skills (4,5).

Conceptual advances and research findings in recent decades have radically changed our understanding of the medical interview process and the teaching of medical interviewing. A variety of scholars, including contributors to DocCom, have articulated the tasks and functions of medical interviewing, and the skills that enable clinicians to accomplish these tasks.

The major functions and tasks that must be accomplished in an effective interview include establishing rapport and building trust, eliciting adequate information, understanding patient concerns, and accomplishing patient education and counseling. Medical students and residents who learn core skills have the ability to conduct thorough interviews in a time-efficient manner (6). A variety of models have been developed that guide students in learning the skills of medical interviewing (6-15). Also, clinical reasoning can be taught and integrated into interviewing skills to
facilitate successful history taking (12, 16-18).

Caring for the patient by assuring that you carry out all the functions of the interview is the focus of many modules in DocCom. In this Module, our emphasis is on the structure and content of the information you seek, although we emphasize that how you get the information helps or hinders the building of relationships and prepares the ground for patient education. Experienced clinicians understand the distinction between the tasks or functions they wish to accomplish during the interview, and the structure of the written history that they will assemble after the interview.

Learners who master core skills through practice, reflection and feedback are able to use the skills flexibly to accomplish the tasks of interviewing. In modules 6 – 12, DocCom authors present and elaborate the tasks and skills agreed on by the Kalamazoo Consensus panel. This group of scholars, including advocates and designers of the various models of interviewing, was able to agree on names and descriptions for 7 essential skills, tasks and functions of medical interviewing; namely, building a relationship with patients, opening the discussion, gathering information, understanding the patient’s perspective, sharing information, reaching agreement, and closing the interview.

Interviewing skills matter

Review these two four minute video clips. Notice that the clinician’s approach in each determines the quantity and quality of information gathered.

Click on the picture-button above to see Movie ONE

Click on the picture-button above to see Movie TWO

What are the components of each approach that were effective and ineffective in eliciting the patient’s story?

Doctor-Centered and Patient-Centered Approaches to Interviewing

Historically, most clinicians conducted “doctor-centered” interviews. That is, they took charge of the interaction to acquire specific details of the patient’s story, in order to diagnose a disease. Most of the questions were guided by the doctors’ clinical reasoning, and their need to elicit certain information to choose among various hypotheses about disease states. However, doctor-centered interviewing often ignored important personal data and lacked the personal and affective content necessary to establish a trusting relationship and understand the patient’s illness experience.
Relationship has always been paramount, but establishing trust became increasingly difficult as biotechnical aspects of disease increased, diagnostic tests became more complex and invasive, specialists emerged, and clinician-patient encounters were more often between complete strangers.

Engel and others started teaching another style of interviewing: the “patient-centered” interview. In this style, the focus is primarily on understanding the patient’s story, allowing the patient to do most of the work, with the clinician being guided by what patients were trying to reveal about the nature of their illness and life. Evidence supports the contention that you will obtain the most accurate and complete biopsychosocial story by integrating patient-centered interviewing with doctor-centered interviewing. However, whether you are using doctor-centered or patient-centered techniques, your dialog is persistently focused on understanding the patient’s story so that you achieve a full understanding of the patient’s illness.

The skills and techniques of “patient-centered” and “doctor-centered” interviewing overlap and are not entirely unique to one style or the other. We present them sequentially below for clarity, but experienced clinicians move back and forth quite flexibly, as called for by the details of a particular encounter with a particular person with particular problems. For example, different skills may be required when encountering patients who tell complete stories in linear sequence, situations that are very urgent, or diseases and illnesses which differ greatly in complexity and severity. Because the medical interview is one of our most complex, intensely personal and potentially invasive procedures, it requires sensitivity, delicacy and a full understanding of skills and strategies, like coronary artery bypass surgery and other procedures we perform. The learning process is complicated, dependent on your personality, attitudes and unique gifts, and the learning continues throughout your professional career, as your experience with disease, illness and patients’ lives expands and broadens. In this module we present ideas about sequencing, timing and chronology that clinically inexperienced learners will find useful for getting started, and more experienced learners will identify new aspects for more intensive study. We could say that you are learning the notes and chords and rhythms of music, so that you can actually make music sooner rather than later. The “old way,” to paraphrase Engel, was to “send students off with a piano for a time and tell them to come back and say what they had discovered about music.” We can do better, thanks to the work of scholars who have studied the interview and the learning process. This module is an overview, and the specific skills involved in performing an interview are discussed in more detail in subsequent modules. We expect your study and/or review of the concepts in this module will prepare you well for the complexities and uncertainties you will encounter as your career in medicine develops.

**PATIENT-CENTERED INTERVIEWING SKILLS**

We divide the process of patient-centered interviewing into 5 steps and 21 sub-steps to enhance learning.(19)

Always integrated with doctor-centered interviewing (steps 6-10), the 5 patient-centered steps focus on the patient: his or her interests, concerns, and questions as well as physical symptoms. The doctor-centered portion occurs next and pins down biopsychosocial details that do not arise during patient-centered interviewing, especially the details needed to diagnose and treat disease. As patients tell their stories during this initial patient-centered phase, hold your own questions about possible disease diagnoses until the doctor-centered phase, which usually will be no more than a few minutes later.

Many terms in the Steps below require further explanation, which you will find in subsequent text or other DocCom modules. It is normal to be a bit overwhelmed as you initially encounter the complexity of patient-centered interviewing. We identify and describe 21 discrete skills, which are easily learned in 2-3 teaching sessions. Clinicians use these skills hundreds of times a day, and the skills will soon become reflexive for you as well. While full mastery of patient-centered
interviewing usually requires more learning time than the more "rote" doctor-centered list of questions, good patient-centered interviewing saves time and produces a more robust picture of the problems at hand.

In this section you'll find in-depth information about:

- **Step 1**
  Set the stage for the interview.

- **Step 2**
  Obtain the patient’s agenda.

- **Step 3**
  Open the History of Present Illness (HPI).

- **Step 4**
  Obtain more details about the HPI.

- **Step 5**
  Transition to the Doctor-Centered portion of the interview.

---

**Step 1: Set the stage for the interview**

**(30 to 60 seconds)**

Bolded statements are the specific sub-steps.

1. Use a simple statement and a handshake to **welcome the patient**. This makes him or her feel valued and sets the proper tone for the interview.

2. Use **the patient’s name**. It is best to use last name until the patient asks you to do otherwise.

3. **Introduce yourself and identify your specific role.** If you are a student, say so and indicate that you are part of the healthcare team. An example of a statement that includes sub-steps 1, 2, and 3 is “Welcome, Mr. Smith. My name is Mary Jones and I am the medical student with Dr. Green. I am here to listen to your story and will be part of your care team.”

4. **Ensure the patient’s readiness and privacy.** Address any physical or emotional conditions that may preclude an effective interaction with the patient e.g., “You look upset. Is everything all right?”

5. **Remove any barriers to communication.** For example you may need to turn off a noisy television or make sure that you have an interpreter for a patient that does not understand English well.

6. Make any necessary physical adjustments in the room and conduct light conversation to **ensure the patient’s comfort and put him or her at ease** with brief light talk e.g., about the weather or the hospital food.

---

**Step 2: Obtain the patient’s agenda; including the chief concern**
1. **Indicate time available** to orient the patient to the expected duration of the visit. “We have about 30 minutes today...”

2. **Indicate your needs.** For example you can say, “I have a list of questions and we will need to do a physical exam...” to indicate your need for sufficient time to obtain the database of a new patient.

3. **Obtain a list of all the issues the patient wants to address.** Hospitalized patients usually present with a clear set of symptoms, identified as the chief complaint. (e.g., "I've been having chest pain," "I've had a fever and bad cough for 3 days.") Outpatients usually come to their doctor with multiple concerns. You will often need to ask prompting questions like "anything else?" or "do you need any prescriptions or forms filled?" because you would like to avoid having important issues arise at the end of the allotted time. You may need to respectfully deter the patient from offering too many details about agenda items at this point with a statement like “That sounds important and we will get to the neck pain in a minute, but I need to know whether there are other things you would like us to accomplish today.”

4. **Summarize and finalize the agenda** to clarify the chief concern, prioritize the list and negotiate with the patient to decide what will be addressed today and what will be deferred to the next visit.

---

**Step 3: Open the History of Present Illness (HPI)**

*(30 – 60 seconds, see DocCom module 8)*

1. **Use an open-ended beginning question or statement** to begin the HPI. It focuses on the chief complaint, the primary problem you identified in Step 2. Because many diseases unfold in characteristic ways, it is always helpful to ask patients to start their stories at the beginning: “You told me you've been having chest pain. Could you tell me all about it, from when it first began until you decided to come into the ER last night.”

2. **Use non-focusing open-ended skills** like silence, neutral utterances (e.g. “uh-huh”) and nonverbal encouragement (nodding, leaning forward) to encourage patients to talk. If they do not talk freely, use open-ended focusing skills (echoing, direct requests - "can you tell me more?" - and summarization) to encourage patients to tell their stories.

3. **Obtain additional data from non-verbal sources** by mentally noting the patient’s physical characteristics, appearance and environment. For example, a framed picture of a young military officer could be a key to eliciting a patient’s anxiety about his son at war.

---

**Step 4: Continue to obtain the HPI**

*(5 – 10 minutes)*

1. (1 minute) We usually start with focusing, open-ended skills (echoing, direct requests and brief summaries) to obtain a good overview of the patient’s **physical symptoms**; e.g., “...so the chest pain began at work with a lot of stress yesterday; say more about the pain.” Avoid
asking specific questions about the details of onset, duration, and radiation of pain at this point and encourage the patient to lead the interaction; that is, don’t ask about where the pain radiates or if the patient was short of breath if they haven’t mentioned it.

2. (3-5 minutes) Next, use focusing open-ended skills to develop the personal or psychosocial context of the patient’s story by shifting your focus to this material. We direct the patient to immediate or previous statements that refer to the patient’s psychosocial circumstances; e.g. “Now tell me about the stress you mentioned.” It is important here to repeatedly apply open-ended skills to what appear to you to be the most important things the patient is saying. This will produce a brief narrative, the patient’s story; e.g., chest pain began during a stressful work situation…patient has been out of work…started this new job one week ago.

3. (30-60 seconds) Use emotion-seeking skills to develop an emotional context. The best way to develop an emotional context is to ask the patient how he or she feels about a personal situation (direct inquiry); e.g., “Missing work right now, how does that make you feel?” If the patient responds with a thought or ignores the inquiry about emotion you can use indirect inquiry to “prime the pump.” You can relate your previous experiences if appropriate and accurate (self-disclosure), or you can ask about the impact of the condition on the patient or their family or about the patient’s explanatory model to generate emotions in him or her when direct inquiry is not effective. When the patient offers an emotion, ask questions to expand your understanding, e.g. “Why does that bother you so much?” “Tell me more about being sad.”

4. (30-60 seconds) Use emotion-response skills to address emotions. Emotion-response skills allow you to express empathy and help patients’ express their emotions fully and without embarrassment; e.g., “...scared about losing your job, I understand; it’s been a hard time for you these last 4 months. Let’s you and I work on this together.” We use the mnemonic NURS to remind us to name the patient’s expressed emotions, make an understanding statement, respect the patient by praising them or acknowledging their plight and to offer our support. Other memory aids that remind us of helpful responses to patients' expression of feelings include PEARLS, which reminds us that statements of partnership, empathy, appreciation (and apology, when appropriate), respect, legitimation and support are effective; or SLRRP, which stands for support, legitimation, reflection, respect, and partnership (module 6 has more detail about the importance of these skills).

5. (remainder of time available) Sub-steps 15-17 generate much new information. Now use repeated cycles of focusing open-ended skills, emotion-seeking skills and emotion-responding skills to further deepen the patient’s story and test hypotheses about their psychosocial situation; concentrate on the personal story as much as possible at this stage. Each cycle amounts to a new chapter of the patient’s story.

---

**Step 5: Transition to the Doctor-Centered portion of the interview**

1. Use 2 or 3 sentences to briefly summarize the patient’s story

2. Check the accuracy of your summary

3. Indicate that the content and style of questioning are about to change (e.g., “Now I’m going to ask you several questions to better understand why you are having a headache, and questions I ask of all my new patients.”)

Patient-centered interviewing is used in virtually all situations, from the new patient to the return
visit, from the emergency room to the consultation, and from surgery to obstetrics. Rarely, however, one does not employ patient-centered inquiry: 1) if the patient’s condition is so critical and urgent that spending a couple minutes this way would be dangerous; 2) if it makes the patient uncomfortable, especially in adolescents and children; 3) if the patient is not mentally competent. Therefore, we can expect to employ patient-centered interviewing in nearly all situations. We now describe the doctor-centered interviewing process that follows.

DOCTOR-CENTERED INTERVIEWING SKILLS

The doctor-centered portion of the interview focuses on testing clinical hypotheses and expands the data base of patient information.

What you have obtained through patient-centered interviewing constitutes the initial part of the patient’s story, and comprises most of the “history of present illness” (HPI). Patient-centered data, however, rarely complete the story. You need more details to make diagnoses of disease and fill in the database; e.g., the family history and social history. The doctor-centered part of the interview differs from the patient-centered part because in it you ask about symptom information not yet mentioned by the patient (details of symptoms already mentioned and new symptoms not yet mentioned) in order to complete the HPI. You also explore other aspects of the patient’s life and history to discover other diseases outside the HPI, assess for disease risk, and come to know the patient better on a personal level. One way to conceptualize this process is to understand that in patient-centered segments of interviews, clinicians provide patients with prompts, and then listen intently to whatever the patient offers about symptoms, timing and other details, feelings, connections, background and so on. In doctor-centered segments, clinicians seek answers to specific questions they have, based both on hypotheses they generate from listening carefully to patients’ stories, and on the need for “routine” background information that experience has shown may provide additional clues (“with whom do you live; do you drink alcohol, are you having sex,” and so on.) (19)

In this section you’ll find in-depth information about:

- **Step 6** Obtaining more details about the HPI
- **Step 7** Past Medical History
- **Step 8** Family History
- **Step 9** Psychosocial History
- **Step 10** Review of Systems
- **Physical Examination**

Step 6: Completion of the HPI

The first task of the doctor-centered component of the HPI is to expand the description of symptoms and obtain details not yet introduced by the patient (e.g., medications, hospitals,
doctors) (19).

**Table 1: Filling in the history of present illness**

1. Define the cardinal features of the patient’s chief concern
2. Define the cardinal features of other symptoms (those already mentioned by the patient and those not yet introduced) in the organ system of the patient’s chief concern
3. Inquire about relevant symptoms outside the involved system
4. Inquire about relevant nonsymptom (secondary) data

The following topics are covered further in this sub-section:

- Expand descriptions of symptom(s) already mentioned by the patient.
- Inquire about symptoms not yet introduced that occur in the same body system.
- Ask about relevant symptoms outside the body system involved in the HPI.
- Elicit the presence or absence of relevant non-symptom data (secondary data) not yet introduced by the patient.
- Scanning Without Interpretation Versus Hypothesis-Testing.
- Becoming patient-centered when appropriate.

---

**Expand descriptions of symptom(s) already mentioned by the patient**

To fully understand a symptom, you need to know its seven “cardinal features”. (19,20) (Table 2)

In the patient-centered interview, patients tell you many of a symptom’s features, but even the most articulate patients are unlikely to mention all possible features when telling their story. Therefore, in the doctor-centered portion of the interview, seek additional details. Start with an open-ended request (“Tell me more about what your chest pain is like”), and then ask more specific closed-ended questions to elicit all the cardinal features (“You pointed to the left side of your chest; does the pain travel anywhere?”). For non-pain symptoms such as weakness or dizziness, not all cardinal features apply (e.g., location, radiation). (module 8)

The **precise location of a symptom** and whether it radiates are diagnostically important (e.g., substernal chest pain radiating down the left arm suggests angina pectoris or myocardial infarction).

The **quality of a symptom** is telling. For example, substernal chest pain that is burning is more likely to be due to esophageal reflux, while squeezing or crushing chest pain is more likely to be cardiac.

Patients sometimes describe their symptoms in odd ways, e.g., “It feels like someone is reaching inside me and tearing me apart.” Such language may hint at psychological problems, although it
may simply emanate from someone who likes colorful language or metaphor.

Use a numeric rating scale to quantify pain, “On a scale of 1 to 10, with 1 being no pain and 10 being the worst you can imagine, what number would you give this pain you’re describing?”

**Chronology** provides important clues to the nature of disease and illness, and coherence to patients’ stories: the primary problem, when it began, its course to the present, and its previous treatment. Fill in all relevant data to understand the big picture -- the patient’s interacting biologic, psychological (personal, emotional), and social dimensions. Organize all features to fit within the chronology.

*Table 2. The 7 cardinal features of symptoms*

1. **Location and radiation**
   - Precise location
   - Deep or superficial
   - Localized or diffuse

2. **Quality**
   - Usual descriptors
   - Unusual descriptors

3. **Quantification**
   - Type of onset
   - Intensity or severity
   - Impairment or disability
   - Numeric description
     - Number of events
     - Size
     - Volume

4. **Chronology**
   - Time of onset of symptom and intervals between recurrences
   - Duration of symptom
   - Periodicity and frequency of symptom
   - Course of symptom
     - Short-term
     - Long-term

5. **Setting**

6. **Modifying factors**
   - Precipitating and aggravating factors
   - Palliating factors

7. **Associated symptoms**

(Modified from Smith RC. *Patient centered interviewing*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins; 2002.)

**Inquire about symptoms not yet introduced that occur in the same body system**
After eliciting a complete picture of the patient’s symptom story, ask about other symptoms in the same body system as the one described in the HPI. In essence, do a focused “review of systems” (ROS) of that one body system. Determine not only which other symptoms are present but also which ones are absent; for example, the absence of dyspnea (shortness of breath on exertion) in a patient with chest pain weighs against a diagnosis of pulmonary embolism.

---

**Ask about relevant symptoms outside the body system involved in the HPI**

Next, ask about symptoms outside the involved body system if they are pertinent to a diagnosis you are considering. For example, in a patient with rheumatoid arthritis who is feeling fatigued, asking about gastrointestinal bleeding symptoms (“any black stools?”). Bleeding is not a joint or musculoskeletal symptom, but is relevant if you suspect gastrointestinal bleeding caused by drug therapy that irritates the stomach. In patients with more than one problem, you will need to inquire about multiple systems in the HPI.

---

**Elicit the presence or absence of relevant non-symptom data (secondary data) not yet introduced by the patient**

Elicit any information concerning medications taken, treatments received, doctor visits and hospitalizations, and diagnoses given. Also, asking questions about possible causes for the diagnoses being entertained may help narrow the differential diagnosis. For example, if pulmonary embolism is a concern, ask about recent long car rides or air travel.

---

**Scanning without interpretation versus hypothesis-testing**

When you first learn medical interviewing you will seldom know what diseases might be causing a patient’s symptoms. By using the patient-centered and doctor-centered approach, you will gather sufficient data to guide your search of texts and other resources to discover likely diagnoses. Early on you must be exhaustive in your interviewing because you are not generating diagnostic hypotheses or interpreting the patient’s responses in real-time to guide your further questioning. (2,5) You may need to return to the patient with additional questions after reading about the problem and developing new hypotheses about what is causing the symptoms.

As your medical knowledge and interviewing experience increase, however, you will begin to have ideas or “hunches” about what might be causing a patient’s symptoms. You can then ask specific questions to test these hypotheses.(19,21) For example, a patient with sudden shortness of breath and chest pain following a long car ride might prompt consideration of pulmonary embolism. To test this hypothesis, ask about hemoptysis (coughing up blood), leg pain, whether the chest pain is worse when taking a deep breath (pleuritic in quality), and if there is a prior history of deep venous thrombosis. With time and practice, knowledge and skills develop sufficiently to allow reliance upon the hypothesis-driven approach, although never completely abandoning the scanning approach.
Becoming patient-centered when appropriate

To provide the most compassionate, effective and efficient service for your patients, you will utilize your patient-centered emotion response skills to express caring and empathy whenever the patient expresses emotion. When patients express emotion, your relationship with them will improve if you respond in real time. You lose trust and erode confidence if you do not respond. When ill, we are all especially vulnerable, and need our care-givers to show us that they are aware of our plight, and especially of our humanness. If our expression of emotion is not acknowledged, it seems as though it fell on deaf ears, and that the listener cares more about something else (the symptom, the lab test, our allergies, or our stomach) than about the vulnerable human being in front of them.

Further, when patients experience more trust and hear your acknowledgement of their feelings, they tend to expand what they have been saying, to trust you with secrets that may be very important clues to both diagnosis and treatment, and to help you as much as they can. Although you may be the best cardiologist in your area, if the patient is not experiencing increasing confidence that you care about him or her as much as you care about the heart, they will "shut down" and cooperate less willingly and fully. Some will even "punish you" (usually unconsciously), withhold information and make your job much harder than it needs to be. For example, if during the Family History the patient becomes tearful and indicates sadness about her father's death (whether it happened last week or 10 years ago), a compassionate response from you, such as “I see that thinking about your father makes you very sad” will be helpful. You will likely learn more about this event and its potential contribution to the present problems, and also firm up your relationship with the patient through your communication of your attempt to better understand her situation.

Step 7: Past Medical History

Although you may have a reasonable picture now that you have obtained relevant details of the HPI, you still need ancillary data to complete the picture.

Some data will be related directly to the HPI (e.g., a recent myocardial infarction will be germane in a patient with bloody stools if he requires major surgery). Other “routine” or ancillary data will not immediately relate to the HPI but is still important (e.g., exercise habits, education, intimate partners, and family history of tuberculosis).

The approach to the remainder of the history is similar to the doctor-centered part of the HPI. Questioning should usually begin in an open-ended fashion in each major area and then be followed by closed-ended questions to obtain details, always remembering to return to the patient-centered skills, and to be aware of the patient's emotions as you go along.

You will obtain specific ancillary data in the Past Medical History (Table 3). Start with open-ended questions (e.g., “Can you tell me about your other medical problems?”) and then focus as needed with closed-ended questions to establish details (e.g., “How long have you had high blood pressure?” “What medicines are you taking for it?”). For chronic illnesses, include the duration of illness or diagnosis date along with current management and level of symptom control, related complications and any recent objective measures of disease activity (e.g, Diabetes Mellitus Type 2, diagnosed 12 yrs ago, controlled with daily oral medications, only known complication is mild renal insufficiency, hemoglobin A1C one month ago 7.2) Table 3 shows a list of all past history components.

Medications
Determine the medications the patient takes, including both dosage and administration (by mouth, vaginally, topical, etc). Ask about over-the-counter medications and herbal, complementary or alternative remedies. Ask specifically about birth control pills, hormones, laxatives, and vitamins, as some patients do not consider these to be medications.

**Allergies**
Ask about environmental, food, and medication allergies. Determine exactly what reaction the patient had to a medication, since many medication “allergies” reported by patients are actually expected side effects (e.g., itching with morphine) or non-allergic adverse reactions (e.g., gastric bleeding from aspirin).

*Table 3: Past medical history*

1. **Inquire about general state of health and past illnesses**
   - Childhood: measles, mumps, rubella, chicken pox, scarlet fever, and rheumatic fever
   - Adult: hypertension, cerebrovascular accident, diabetes, heart disease, tuberculosis, venereal disease, cancer
   - Chronic illnesses: include duration of illness or diagnosis date along with current management and level of symptom control, related complications and recent objective measures of disease activity

2. **Inquire about past injuries, accidents, psychotherapy, unexplained problems**

3. **Elicit past hospitalizations** (medical, surgical, obstetric, and psychiatric) including dates

4. **Review the patient’s immunization history**
   - Childhood: measles, mumps, rubella, polio, hepatitis B, tetanus/pertussis/diptheria
   - Adult: tetanus boosters, hepatitis B, hepatitis A, influenza, pneumococcal pneumonia

5. **Obtain the patient’s obstetric history and menstrual history**
   - Age of menarche, cycle length, length of menstrual flow, number of tampons/pads used per day
   - Number of pregnancies, complications; number of live births, spontaneous vaginal deliveries/cesarean section; number of spontaneous and therapeutic abortions
   - Age of menopause

6. **List current medications, including dose and route**
   - Ask specifically about over-the-counter medicines, alternative remedies, contraceptives, vitamins, laxatives

7. **Review allergies**
   - Environmental, medications, foods
   - Ensure that medication “allergies” are not actually expected side effects or nonallergic adverse reactions

8. **Health promotion**
   - **Safety**
     - Seatbelt use
     - Safety helmet use
     - Smoke detectors in home
     - Safe gun storage
   - **Screening**
     - Cervical cancer
     - Breast cancer
Step 8: Family History (FH)

Ask about the age and health of the patient's immediate family as well as the causes of death, when they died, and ages of first-degree relatives.

Information from the FH frequently gives you clues about the patient's concerns. For example, a patient presents with chest pain, and you learn that his brother died a year earlier from a heart attack. Or the patient is 50 years old and you learn that her mother died at age 51 from breast cancer.

Screen for genetic and environmental illnesses by inquiring about a family history of diseases such as cancer, heart disease, diabetes, tuberculosis, alcoholism, and asthma.

Table 4: Family history

1. Inquire about age and health (or cause of death) of grandparents, parents, siblings, and children

2. For patients who do not readily volunteer information, depending on your thinking about the likely causes of the patient's symptoms, you may need to ask specifically about a family history of:
   - Diabetes
   - Tuberculosis
   - Cancer
   - Hypertension
   - Stroke
   - Heart disease
   - Hyperlipidemia
   - Bleeding problems
   - Anemias
   - Kidney disease
   - Asthma
   - Tobacco use
   - Alcoholism
   - Weight problems
   - Symptoms similar to those the patient is experiencing
   - Mental illness
     - depression
     - suicide
     - schizophrenia
     - multiple somatic concerns
Step 9: Psychosocial History

The psychosocial history describes behaviors and other personal factors that may impact disease and illness risk, severity and outcome; it also helps you to get to know the patient. The psychosocial history complements the personal and emotional information obtained in the patient-centered portion of the interview.

As you gain experience, you learn which questions are most important to ask for a particular patient encounter. Some highlighted items in Table 5 will identify targets for risk factor modification, and are infrequently spontaneously brought up by patients. They need open and non-judgmental discussion, which builds trust and relationship, and assures the most accurate information. You may need to obtain this type of information over multiple patient encounters.

Some of the most important areas of the Psychosocial History are detailed below in this section:

- **Habits**
- **Personal Issues**
- **Domestic Partner Violence**
- **Spirituality and Religious Beliefs**
- Table listing all psychosocial history components

### Habits

Ask about tobacco use, including forms of tobacco (e.g., pipe, snuff, chewing tobacco) and number of pack-years for cigarette use. (A pack-year is one pack of cigarettes per day for a year. If a patient smoked 2 packs of cigarettes per day for 10 years, you would say the patient was a 20 pack-year smoker.)

Determine whether the patient consumes alcohol and whether it may be a health problem. Ask “Do you drink alcohol”, and follow up a “yes” answer with the "CAGE" questions:

"Have you ever felt you should cut down on your drinking?"
"Have people annoyed you by criticizing your drinking?"
"Have you ever felt bad or guilty about your drinking?"
"Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?" (eye-opener) (For a full discussion of screening for alcoholism, see module 29.)

Ask about the patient's use of drugs: "Have you used marijauna, street drugs, or prescription drugs to have fun or get high in the last year?" If yes, then ask, "have you felt you wanted or needed to cut down on your use of this/ those drugs in the last year?"

### Personal issues

**Occupation**

A patient’s occupation can affect health. Ask, “What kind of work do you do? What other jobs
have you had? Have you ever been exposed to fumes, dust, radiation, or loud noise at work? Do you think your work is affecting your symptoms now?” If the patient does not work outside the home, ask what a typical day is like.

**Stress**
Most patients have stress in their lives, which may contribute substantially to the onset and maintenance of their symptoms. A simple question often elicits an important story: “Tell me about the stress in your life” “Is life stressful these days?”

**Mood**
Depressive and anxiety disorders each occur in 11-12 % of people, and up to 50% of depressive disorders are missed in primary care. Simple questions will guide you in whether to seek further details to establish the presence of an important disorder. “So- how are your spirits these days?” “Are you getting any pleasure in life?” “How is your sleep?”

**Home Life**
A good way to inquire about home life is to ask, “Does anyone else live at home with you? Tell me about him or her.” “How do you get along?”

**Sexuality**
Asking about a patient’s spouse or significant other should provide a comfortable segue into asking about sexuality.(23) Do not assume a patient’s sexual orientation or sexuality. Gender-neutral language (e.g., "partner") communicates to gay, lesbian, bisexual, and transgender patients that it is safe for them to be honest and open with you. You can elicit basic important information with the questions shown below.

- “Is there someone special in your life? Are you and this person having sex?”
- “Has your illness affected your sexual functioning?”
- “Do you have sex with men, women, or both?”

Many situations will require that you ask more details, such as the questions below:

- “Do you have sex with anyone who might be at risk for having sexually transmitted diseases or HIV (injection drug users, cocaine users, prostitutes, unknown partners, gay or bisexual men)?”
- “Are you using condoms to prevent disease? What percent of the time?”
- “Do you have any other sexual relationships that I should know about?”

Some patients and some clinicians are bothered by these questions, and we explore the issues in more detail in module 18.

---

**Domestic Partner Violence**

Domestic violence occurs in as many as 1 of every 4 US families. Both because this is so frequent, and because patients are unlikely to broach this issue themselves, clinicians must sensitively inquire about domestic partner violence. One suggested approach (24) is “Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? Has anyone ever forced you to have sexual activities?” (We will explore more about this in module 28)

---

**Spirituality and Religious Beliefs**

Spirituality and religious beliefs are important to many patients, especially in times of illness. The following questions will get you started (25):
“Do you consider yourself to be a spiritual or religious person?”

“What importance does faith have in your life?”

“Are you a part of a spiritual or religious community?”

(We explore this issue in more detail in Module 19.)

---

**Psychosocial history**

**Table 5: Psychosocial history**

- Living arrangement (with whom, how are things at home?)
- Work/daily activities (satisfaction, exposures)
- Diet
- Physical activity/exercise history
- Substance use (current or past): tobacco, alcohol, drugs, caffeine
- Financial concerns
- Personal relationships and support systems (Who do you count on? How have people responded to your illness?)
- Sexuality (orientation, risk assessment, problems or concerns)
- Domestic violence/abuse
- Stress
- Mood
- Health beliefs
- Spirituality/religion
- Important life experiences
  - Upbringing and family relationships
  - Schooling
  - Military service
  - Financial situation
  - Aging
  - Retirement
  - Life satisfaction
  - Cultural/ethnic background
- Functional status (taking care of self - toileting, bathing, dressing; managing daily activities - working, shopping, cooking, house cleaning)

*Items in bold should be asked about in most new patient encounters: they have high yield for risk factor modification, assist in building the doctor-patient relationship, and/or are important to patients but rarely brought up by them*

---

**Step 10: Review of Systems**

The review of systems (ROS) is a head-to-toe survey to uncover symptoms not elicited earlier in the interview. You already performed part of the ROS while filling in the HPI. Now, survey the remaining body systems to ensure that the database is complete (Table 6). From data gathered in the HPI and past medical history you will already have a reasonable idea about the major diagnostic possibilities. The ROS is not used to elucidate key features of the present illness. Rather, it is used to screen for any additional symptoms unrelated to the HPI (e.g., abnormal rectal bleeding in a patient with suspected pneumonia). As you gain experience, you will settle on
a few questions from each system which you routinely use, and you will become proficient and efficient at asking them. You cannot ask about every possible symptom, so you will select some that help you cover important bases. Most importantly the direct and attentive way that you ask these “routine” questions signals to patients both your biomedical competence, and your invitation to listen about any symptom, illness or issue that might be relevant. The ROS completes your interview. After completing the interview you will usually begin examining the patient. Some clinicians, in the interest of saving time, will ask ROS questions as they are going through relevant segments of the physical exam.

Table 6 below lists all review of systems components:

Table 6: Review of systems.

(medical terms [used in oral and written presentations] are in parentheses)

1. General
   - Usual state of health
   - Fever
   - Chills
   - Night sweats
   - Appetite
   - Weight change
   - Weakness
   - Fatigue
   - Pain
   - Apathy or loss of interest

2. Skin
   - Rashes
   - Itching
   - Hives
   - Easy bruising
   - Change in moles
   - Lumps
   - Loss of pigment
   - Change in hair pattern

3. Head
   - Dizziness
   - Headaches
   - Fainting
   - Head injuries

4. Eyes
   - Use of glasses
   - Change in vision
   - Double vision (diplopia)
   - Pain
   - Redness (erythema)
   - Discharge
   - History of glaucoma
   - Cataracts
   - Dryness

5. Ears
   - Hearing loss
   - Use of hearing aid
   - Discharge
   - Pain
   - Ringing (tinnitus)
   - Nose
   - Nosebleeds (epistaxis)
- Discharge
- Loss of smell (anosmia)

6. **Mouth and Throat**
- Bleeding gums
- Painful swallowing (odynophagia)
- Difficulty swallowing (dysphagia)
- Hoarseness
- Tongue burning (glossodynia)
- Tooth pain

7. **Neck**
- Lumps
- Goiter
- Stiffness

8. **Chest**
- Cough
- Pain
- Shortness of breath (dyspnea)
- Sputum production
- Coughing blood (hemoptysis)
- Wheezing

9. **Breasts**
- Lumps
- Milky discharge (galactorrhea)
- Bleeding from the nipple
- Pain
- Self-examination
- Breast feeding history

10. **Cardiac**
- Chest pain
- Palpitations or fluttering in the chest
- Shortness of breath (dyspnea)
  - on exertion
  - lying flat (orthopnea)
  - awakening from sleep (paroxysmal nocturnal dyspnea)
- Swelling of feet or other regions (edema)

11. **Vascular**
- Pain in legs, calves, thighs, hips, buttocks when walking (claudication)
- Leg swelling
- Blood clots (thrombophlebitis)
- Ulcers

12. **Gastrointestinal**
- Loss of appetite
- Nausea
- Vomiting (emesis)
- Vomiting blood (hematemesis)
- Swallowing difficulty/pain
- Heartburn (dyspepsia)
- Abdominal pain
- Constipation
- Diarrhea
- Change in stool color/caliber
- Black, tarry stools (melena)
- Rectal bleeding (hematochezia)
- Hemorrhoids

13. **Urinary**
- Frequent urination (frequency)
- Awakening at night to urinate (nocturia)
14. **Female Genital**
- Lesions/discharge/itching
- Age of first menstrual period (menarche)
- Interval between menses
- Duration of menses
- Amount of flow
- Last menses
- Bleeding between periods
- Pregnancies
- Abortions/miscarriages
- Libido
- Painful intercourse
- Orgasm function
- Age at menopause
- Menopausal symptoms
- Postmenopausal bleeding

15. **Male Genital**
- Lesions/discharge
- Erectile function
- Orgasm function
- Testis swelling/pain
- Libido
- Hernia

16. **Neuropsychiatric**
- Fainting
- Paralysis
- Numbness
- Tingling
- Tremors
- Loss of memory
- Mood changes
- Sleep
- Nervousness
- Speech disorders
- Dizziness or vertigo
- Poor balance (ataxia)
- Hallucinations
- Seizures

17. **Hematologic**
- anemia
- easy bruising or bleeding
- past transfusions and any reactions to those

18. **Musculoskeletal**
- Weakness
- Muscle pain
- Stiffness
- Arthritis
- Gout
RECORDING THE PATIENT’S HISTORY: THE MEDICAL HISTORY WRITE-UP

The written description of patient information in the medical record is called the medical ‘write-up.’ It usually contains the patient’s history, physical examination, initial diagnostic tests, problem list, assessment, and plans for further investigations and treatment. We will focus here only on the write-up of the patient’s history.

A well-organized write-up synthesizes information from different parts of the interview. We suggest the following format for recording the data:

**Identifying Data**
This information includes the patient’s age, gender, race, medical record number, telephone number of nearest relative in case of emergency and referral source, if any.

**Source and Reliability of Information**
State the source of the data (e.g., patient, parent) and their reliability, noting any concerns you might have. This signals the quality of the data to the reader.

**Chief Complaint and Agenda**
State the patient’s most bothersome symptom (known as the chief complaint or chief concern) using his or her words if possible and then summarize the full, negotiated agenda from Step 2 with a list.

**History of Present Illness**
The HPI is the most important part of the history and is usually written in narrative form. In the beginning, you may simply record the chronology of symptoms as the patient reports them. As you gain more understanding about disease patterns and experience you should record the information in a way that will lead students and clinicians to the same diagnostic conclusions you are considering.

Begin the section with an overview of the chief concern and other symptoms (primary data) that fit together to best describe the most likely underlying disease process. Indicate when each began and provide their pertinent cardinal features. Then record the absence of relevant symptoms. In determining which symptoms are relevant, a beginning student may only consider other symptoms in the same body system as the chief complaint. As you develop a better understanding of disease, you should also include symptoms from other body systems. For example a beginning student may record the presence or absence of symptoms only in the Musculoskeletal and General System in a patient with arthritis who complains of fatigue, but an advanced student may also record the absence of gastrointestinal bleeding in the patient who is at risk because of arthritis medication. Next, record the relevant positive and negative non-symptom (secondary) data, such as data about previous doctors and healthcare facilities, diagnostic tests and results, treatments and results, specific habits, and occupation that are important for understanding the etiology (cause), pathogenesis (mechanism) and prognosis of the patient’s problem.

Finally, record the synthesized personal data obtained from both the patient-centered and doctor-centered process to display your understanding of how the patient’s personal and emotional dimensions are linked with his or her physical problem. Sometimes this link is clearly causal, but even when it is not, we can describe a personal context of the physical problem in all patients.

**Other Current Active Problems (OCAP)**
This section contains other active problems that are unrelated the patient’s HPI. As with the HPI, these problems should be described with the appropriate primary and secondary data. The remainder of the write-up (Past Medical History, Psychosocial History, Family History, Review of Systems, Physical Exam, Laboratory Tests, Assessment, Problem List and Plan) can be recorded in an outline form or combination of narrative and outline form using the information obtained from
the remainder of the doctor-centered process.

**Problem List**
The problem list is a numbered listing of all active problems (e.g. chest pain, diabetes), past problems (e.g. s/p cholecystectomy 1998) and future risk of problems (e.g. family history colon cancer). Every comprehensive write-up requires a complete problem list. Every problem or disease identified within the evaluation, from HPI to ROS, is included in the problem list. In addition, unexpected abnormal findings found on physical examination or laboratory testing are also listed in the problem list.

---

**CONCLUSION**

Integrating patient-centered interviewing with doctor-centered interviewing results in the most complete, accurate and diagnostically powerful dataset – the patient’s biopsychosocial story.

As well, by interviewing in this way, you build a strong doctor-patient relationship that will be important as you negotiate further testing and therapy for the patient’s illness.

The relationship itself is also therapeutic for the patient and will improve your professional satisfaction.

---

**TABLES**

This section includes all the tables used in this module for further reference.

1. Filling in the history of present illness
2. The 7 cardinal features of symptoms
3. Past medical history
4. Family history
5. Psychosocial history
6. Review of systems

---

**Table 1: Filling in the history of present illness.**

1. Define the cardinal features of the patient’s chief concern
2. Define the cardinal features of other symptoms (those already mentioned by the patient and those not yet introduced) in the organ system of the patient’s chief concern
3. Inquire about relevant symptoms outside the involved system
4. Inquire about relevant non symptom (secondary) data
Table 2: The 7 cardinal features of symptoms

1. **Location and radiation**
   - Precise location
   - Deep or superficial
   - Localized or diffuse

2. **Quality**
   - Usual descriptors
   - Unusual descriptors

3. **Quantification**
   - Type of onset
   - Intensity or severity
   - Impairment or disability
   - Numeric description
     - Number of events
     - Size
     - Volume

4. **Chronology**
   - Time of onset of symptom and intervals between recurrences
   - Duration of symptom
   - Periodicity and frequency of symptom
   - Course of symptom
     - Short-term
     - Long-term

5. **Setting**

6. **Modifying factors**
   - Precipitating and aggravating factors
   - Palliating factors

7. **Associated symptoms**

(Modified from Smith RC. Patient centered interviewing. 2nd ed. Philadelphia: Lippincott Williams & Wilkins; 2002.)

Table 3: Past medical history

1. **Inquire about general state of health and past illnesses**
   - Childhood: measles, mumps, rubella, chicken pox, scarlet fever, and rheumatic fever
   - Adult: hypertension, cerebrovascular accident, diabetes, heart disease, tuberculosis, venereal disease, cancer
- Chronic illnesses: include duration of illness or diagnosis date along with current management and level of symptom control, related complications and recent objective measures of disease activity

2. **Inquire about past injuries, accidents, psychotherapy, unexplained problems**

3. **Elicit past hospitalizations** (medical, surgical, obstetric, and psychiatric) including dates

4. **Review the patient’s immunization history**
   - Childhood: measles, mumps, rubella, polio, hepatitis B, tetanus/pertussis/diptheria
   - Adult: tetanus boosters, hepatitis B, hepatitis A, influenza, pneumococcal pneumonia

5. **Obtain the patient’s obstetric history and menstrual history**
   - Age of menarche, cycle length, length of menstrual flow, number of tampons/pads used per day
   - Number of pregnancies, complications; number of live births, spontaneous vaginal deliveries/cesarean section; number of spontaneous and therapeutic abortions
   - Age of menopause

6. **List current medications, including dose and route**
   - Ask specifically about over-the-counter medicines, alternative remedies, contraceptives, vitamins, laxatives

7. **Review allergies**
   - Environmental, medications, foods
   - Ensure that medication “allergies” are not actually expected side effects or nonallergic adverse reactions

8. **Health promotion**
   - **Safety**
     - Seatbelt use
     - Safety helmet use
     - Smoke detectors in home
     - Safe gun storage
   - **Screening**
     - Cervical cancer
     - Breast cancer
     - Prostate cancer
     - Colon cancer
     - Lipids
     - Hypertension
     - Diabetes
     - HIV
     - Syphilis
     - Tuberculosis
     - Glaucoma

---

**Table 4: Family history**

1. Inquire about age and health (or cause of death) of grandparents, parents, siblings, and children
2. For patients who do not readily volunteer information, you may need to ask specifically about a family history of:
   - Diabetes
   - Tuberculosis
   - Cancer
   - Hypertension
   - Stroke
   - Heart disease
   - Hyperlipidemia
   - Bleeding problems
   - Anemias
   - Kidney disease
   - Asthma
   - Tobacco use
   - Alcoholism
   - Weight problems
   - Symptoms similar to those the patient is experiencing
   - Mental illness
     - depression
     - suicide
     - schizophrenia
     - multiple somatic concerns

---

**Table 5: Psychosocial history**

- Living arrangement (with whom, how are things at home?)
- Work/daily activities (satisfaction, exposures)
- Diet
- Physical activity/exercise history
- Substance use (current or past): tobacco, alcohol, drugs, caffeine
- Financial concerns
- Personal relationships and support systems (Who do you count on? How have people responded to your illness?)
- Sexuality (orientation, risk assessment, problems or concerns)
- Domestic violence/abuse
- Stress
- Mood
- Health beliefs
- Spirituality/religion
- Important life experiences
  - Upbringing and family relationships
  - Schooling
  - Military service
  - Financial situation
  - Aging
  - Retirement
  - Life satisfaction
  - Cultural/ethnic background
- Functional status (taking care of self - toileting, bathing, dressing; managing daily activities - working, shopping, cooking, house cleaning)

*Items in bold should be asked about in most new patient encounters: they have high yield for*
risk factor modification, assist in building the doctor-patient relationship, and/or are important to patients but rarely brought up by them

Table 6: Review of systems.

*(medical terms [used in oral and written presentations] are in parentheses)*

1. **General**
   - Usual state of health
   - Fever
   - Chills
   - Night sweats
   - Appetite
   - Weight change
   - Weakness
   - Fatigue
   - Pain
   - Apathy or loss of interest

2. **Skin**
   - Rashes
   - Itching
   - Hives
   - Easy bruising
   - Change in moles
   - Lumps
   - Loss of pigment
   - Change in hair pattern

3. **Head**
   - Dizziness
   - Headaches
   - Fainting
   - Head injuries

4. **Eyes**
   - Use of glasses
   - Change in vision
   - Double vision (diplopia)
   - Pain
   - Redness (erythema)
   - Discharge
   - History of glaucoma
   - Cataracts
   - Dryness

5. **Ears**
   - Hearing loss
   - Use of hearing aid
   - Discharge
   - Pain
   - Ringing (tinnitus)
   - Nose
   - Nosebleeds (epistaxis)
   - Discharge
   - Loss of smell (anosmia)

6. **Mouth and Throat**
• Bleeding gums
• Painful swallowing (odynophagia)
• Difficulty swallowing (dysphagia)
• Hoarseness
• Tongue burning (glossodynia)
• Tooth pain

7. Neck
• Lumps
• Goiter
• Stiffness

8. Chest
• Cough
• Pain
• Shortness of breath (dyspnea)
• Sputum production
• Coughing blood (hemoptysis)
• Wheezing

9. Breasts
• Lumps
• Milky discharge (galactorrhea)
• Bleeding from the nipple
• Pain
• Self-examination
• Breast feeding history

10. Cardiac
• Chest pain
• Palpitations or fluttering in the chest
• Shortness of breath (dyspnea)
  • on exertion
  • lying flat (orthopnea)
  • awakening from sleep (paroxysmal nocturnal dyspnea)
• Swelling of feet or other regions (edema)

11. Vascular
• Pain in legs, calves, thighs, hips, buttocks when walking (claudication)
• Leg swelling
• Blood clots (thrombophlebitis)
• Ulcers

12. Gastrointestinal
• Loss of appetite
• Nausea
• Vomiting (emesis)
• Vomiting blood (hematemesis)
• Swallowing difficulty/pain
• Heartburn (dyspepsia)
• Abdominal pain
• Constipation
• Diarrhea
• Change in stool color/caliber
• Black, tarry stools (melena)
• Rectal bleeding (hematochezia)
• Hemorrhoids

13. Urinary
• Frequent urination (frequency)
• Awakening at night to urinate (nocturia)
• Infrequent urination
• Abrupt urge to urinate (urgency)
• Difficulty starting stream
- Incontinence or loss of control of urination
- Blood in urine (hematuria)
- Pain on urination (dysuria)

14. **Female Genital**
   - Lesions/discharge/itching
   - Age of first menstrual period (menarche)
   - Interval between menses
   - Duration of menses
   - Amount of flow
   - Last menses
   - Bleeding between periods
   - Pregnancies
   - Abortions/miscarriages
   - Libido
   - Painful intercourse
   - Orgasm function
   - Age at menopause
   - Menopausal symptoms
   - Postmenopausal bleeding

15. **Male Genital**
   - Lesions/discharge
   - Erectile function
   - Orgasm function
   - Testis swelling/pain
   - Libido
   - Hernia

16. **Neuropsychiatric**
   - Fainting
   - Paralysis
   - Numbness
   - Tingling
   - Tremors
   - Loss of memory
   - Mood changes
   - Sleep
   - Nervousness
   - Speech disorders
   - Dizziness or vertigo
   - Poor balance (ataxia)
   - Hallucinations
   - Seizures

17. **Hematologic**
   - anemia
   - easy bruising or bleeding
   - past transfusions and any reactions to those

18. **Musculoskeletal**
   - Weakness
   - Muscle pain
   - Stiffness
   - Arthritis
   - Gout

---

**LITERATURE REFERENCES:**
Welcome to DocCom Module 6: "Build the relationship"

by Julian Bird, MD, and Steven Cole, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Julian Bird, M.D. and Steven Cole, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient (Ms. Grant): Blanche Watts
Clinician on camera: Julian Bird, MD
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History: 3.0 - 10/14/2011 - HTML5 version implemented - iPod
A positive doctor-patient relationship is the key to medical care. Substantial evidence indicates that a relationship of trust and respect promotes better adherence to treatment recommendations, better physical and emotional outcomes, the disclosure of patients' hidden concerns, and furthermore, that the absence of a good relationship is an impairment to high quality medical care.

Questions for Reflection:

1. Think about your own ways of connecting with friends and others. Which of these skills could you apply to building relationships with patients?

2. Which of these skills do you consider most important for building relationships with patients?

3. What attitudes do you have about yourself that might get in the way of building relationships with patients?

4. How do people see you as a person? What are your hopes for how patients will think of you?

Key Principles:

1. Relationship building is crucial at the start of the contact but must continue throughout and be integrated with data gathering and patient education

2. Relationship building reflects a combination of non-verbal behavior (attentiveness, responsiveness and warmth) and explicit comments and questions to show a caring interest in the person, not just the medical condition

3. Relationship building interventions work best when they reflect your genuine thoughts and feelings

4. Relationship building interventions should be moderated by your awareness of your own biases and emotional reactions in responding to patients’ personal / emotional issues
Learning goals:

At the conclusion of this module, you will be able to:

- State at least five reasons why relationship building is key to medical care
- State three key principles of relationship building
- Demonstrate five basic relationship building skills

INTRODUCTION

The clinician-patient relationship stands as the cornerstone of clinical medicine. The first essential element of the interview, Build the Relationship, utilizes a set of emotional response skills which are among the most important communication skills the clinician can develop.

Patients expect their doctors to be knowledgeable and technically competent. But they also want their doctors to be reassuring, supportive, and emotionally available.

Clinicians with effective relationship skills will have more satisfied patients who will better adhere to treatment recommendations. Furthermore, the clinician with effective relationship skills will cope with emotionally troubling situations better and will, in general, find the clinical practice of medicine more enjoyable. Such a clinician will be able to give more emotionally to patients and will, in turn, get more satisfying responses from them. There is a substantial body of evidence about the importance of clinician-patient relationships in outcomes of care.

For example, in a study of over 7000 patients, clinicians' comprehensive ("whole person") knowledge of patients and patients' trust in their clinician were the variables most strongly associated with adherence, and trust was the variable most strongly associated with patients' satisfaction with their clinician. (1) You can achieve a "whole person” knowledge of patients by building supportive, caring relationships. In a meta-analysis of studies on the relationships of clinician communication and outcomes of care, clinicians’ providing positive affect, empathy and support emerged as an important factor in promoting positive patient outcomes. This study found that when clinicians ask about patients' understanding, concerns, expectations, and impact of illness on function, it leads to decreased anxiety and promotes symptom resolution. Clinicians asking about patients’ feelings leads to decreased patient distress, and when clinicians provide support and empathy, there is both decreased patient distress and better symptom resolution. In studies of medical outcomes, when patients feel that they have been able to express themselves fully (feelings, opinions, information), they later have improved health and functional status, and better BP control. Moreover, when patients feel there has been a full discussion of their problems, they experience better symptom resolution. (2)

RELATIONSHIP SKILLS

This module describes a group of basic relationship skills that help build doctor-patient rapport.

- **Attentiveness and Warmth**
  Attentiveness to the patient as a whole person and not just attentiveness to diagnosis and management of the diseased part of the person, is the prerequisite of all relationship
Attentiveness and Warmth

Attentiveness to the patient as a person is the prerequisite of all relationship building.

Not only does the demonstration of warm attentiveness in itself create a positive impact but also all the other components of relationship building depend on attentiveness. If you do not constantly pay attention to the person as well as to diagnosis and management you will fail to spot the appropriate moments for demonstrating empathy, respect, support and partnership.

Attentiveness is demonstrated by both non-verbal and verbal behaviors.

Non-verbal behavior and ‘para-verbal’ behavior (tone and pacing of speech) are the most powerful determinants of the emotional impact of any interaction. Warmth and attentiveness are demonstrated through eye contact, voice tone, nods and uh-huh’s, responsive facial expression and forward posture. Attentive silence can have a powerful positive impact and is considered in more detail in this module’s section on empathy. A more detailed overview of non-verbal behavior appears in module 14.

You should strive for consistency between your verbal and nonverbal behavior. For example, if there is a disjunction between your verbal statements of concern and your nonverbal behavior, which may reflect your disapproval of a patient’s behavior, your nonverbal message will usually prevail for the patient. (3)

An emerging body of research supports these contentions. Doctors who establish appropriate eye contact are more likely to detect emotional distress in their patients. Doctors who perform better on tests of nonverbal sensitivity have patients who are more satisfied. Doctors who lean forward and have a forward head lean and open body posture also have more satisfied patients. (4)
In addition, patients’ nonverbal behaviors are keys to their emotional lives. Most patients express their emotional state through facial expression, body posture, movement, tone of voice, inflection, and physical manifestations of autonomic nervous system reactivity (sweaty palms, flushed face, etc.). Clinicians interested in understanding their patients' emotional states will look for these signs and consider their importance at every stage of the communication process.

In general, you should establish and keep comfortable eye contact with the patient throughout the interview. This is essential for active and effective listening and also to be able to observe emotional cues as they arise. As with all rules, there are exceptions: angry, suspicious, and/or paranoid patients can perceive steady eye contact as provocative.

Thoughtful attention to the use of space also facilitates rapport. Vertical space between doctor and patient should be minimized (e.g., not standing while the patient sits) and horizontal space should be carefully planned (e.g., not too close or too far).

The power of the various relationship building skills you will master, and the intimacy and social power differentials that accompany caring for people who are ill and vulnerable require you to be especially mindful of appropriate boundaries in your doctor – patient relationships. Doctors’ skills repertoire needs to include respectful ways of reinforcing those boundaries if and when the need arises. (module 41)

Verbal demonstration of attentiveness is largely through ‘active listening’ (described in more detail in module 8, "Gather Information"). Active listening includes ‘continuers’ (encouraging comments) such as ‘please tell me more’ and reflection (repetition) of key phrases used by the patient ("I see ...the pain was severe"). Expression of your own emotional response to the patient’s experience (e.g., "my goodness .. how awful") can also be a powerful way to indicate attentiveness. However, your expressions of emotion must be titrated so that they do not burden or distract the patient.

### Empathy

Empathy is a term indicating one person’s appreciation, understanding, and acceptance of someone else's emotional situation, inner experience and perspectives. When a clinician communicates this understanding, the patient feels heard, understood and accepted, and that the clinician has tried to “walk a mile in my shoes”

The communication of empathy is one of the most helpful, meaningful, and comforting interventions one person can have with someone else. A parent soothes an upset child by letting the child know that the distress is understood, appreciated, and accepted. Friends can do the same. Similarly, a clinician can build rapport and respond to patients' emotions best by the communication of empathy. (5)

Sometimes clinicians are reluctant to encourage the patient to express feelings more deeply by expressing empathy. They may feel that this will open a "Pandora’s box" of emotions or that empathic comments will "push" patients to express feelings that they might otherwise wish to keep private. Research suggests though, that it is helpful and supportive to allow patients some opportunities for the ventilation of feelings that are near the "surface" of awareness. Such interventions help develop rapport and trust. And contrary to the worry that expressions of empathy can unnecessarily prolong the interview, there is evidence that a little empathy goes a long way (6), and can make your interactions with patients more efficient.

The communication of an empathic understanding of a patient’s predicament is clearly the most important relationship-building skill the clinician can possess. There are many different ways to communicate empathy effectively. The challenge of learning empathic skills lies in the ability to master basic interventions and to integrate these into a natural interpersonal style that feels genuine to you and, as such, is likely to be perceived as genuine by the patient.
Nonverbal behaviors can sometimes communicate empathy more effectively than can concrete statements. A sympathetic look, attentive silence, and a hand on the shoulder can all accomplish a great deal towards letting the patient know you are emotionally in tune with the patient's distress. Genuine interest in the patient's life, feelings, worries, expectations and hopes communicate empathy.

Most students and clinicians already possess natural empathic abilities, but the challenges of medical practice often require the development of additional skills. Clinicians need to ask patients about very personal issues, and patients will often tell their clinicians things they tell no one else, such as sexual problems or stories of physical and sexual abuse. It takes learning specific skills, practice and experience to become comfortable eliciting and listening to patients' most personal concerns.

A word on attentive silence: It is a valuable skill: it wordlessly communicates concern, interest and respect. It counters the impressions many patients hold that "doctors don't listen to their patients." It gives patients an opening to discuss their most troubling issues. When a patient interrupts a narrative and falls silent, or expresses a strong emotion, it is wise to remain silent. If the silence lasts more than about 5 seconds, you can gently say, "what are you feeling?" or "are you able to talk about it?" Most beginning learners have great difficulty with attentive silence, often feeling the need to change the subject or reassure the patient. But attentive silence has many rewards for patient and clinician.

This chapter describes two operational components of empathic communication, "reflection" and "legitimation," that can be used to facilitate your responses to patients' emotional distress. Reflection refers to your description of the emotion experienced by the patient and legitimation refers to the clinician's confirmation that the emotion is understood and accepted.

**Empathy: Reflection**

Reflection is a fundamental relationship skill used in everyday encounters between friends and family members. The power of reflection is emphasized in the writings of Carl Rogers and other authors. Here, reflection refers to a clinician's acknowledgement of an observed feeling or emotion in a patient. (7)

If you notice that a patient begins to look sad when discussing the illness of a parent, examples of ways you can "reflect" this feeling include the following:

**Clinician:**

You look sad right now. or
I can see this is upsetting to you. or
This is hard to talk about.
This type of reflective comment usually helps you communicate empathic concern for the patient's emotional situation. In practical terms, such comments usually give patients permission to talk more about their feelings. Patients often then go on to reveal important information that helps you better understand their illnesses.

Click on the picture-button on the left to see an example of reflection.

The specific words you use are much less important than the fact that you have interrupted the factual exchange of information to notice and respond to the patient's emotional state. This is a critically important event in the building of a relationship with a patient and demonstrates to the patient that you are concerned about the patient as a person and his or her emotional experiences.

When you make reflective comments about sadness, patients will often begin to cry, which can make you uncomfortable, and want to either “fix” the problem, reassure the patient, or change the topic. However, a patient’s crying is a good sign – it indicates that the patient trusts you. Also, crying in the presence of a caring clinician is often therapeutic for patients. It is best to respond to patients’ tears with attentive silence, and offering a tissue.

After you make reflective comments, patients may indicate that they do not wish to discuss their emotional reactions, and you should of course respect these desires. It is important however, that you do not confuse your own discomfort or desire to avoid emotional issues with the inference that it is the patient who wishes to avoid these topics. Sometimes, patients are reluctant to talk about difficult emotional issues because of guilt or shame (8), or their worry that you will not be open to listening, or might be judgmental. Often, a comment such as, "it’s pretty hard to talk about this..." followed by attentive silence, will reassure the patient and enable them to disclose their feelings.

On the other hand, if you do not acknowledge a patient's manifest feelings, the patient will feel less understood and unconfirmed. Such feelings undermine doctor-patient rapport and actually interfere with collection of data.

One of the cardinal rules of good interviewing is the following:

**Respond to a patient's feeling as soon as it appears**

Remember that reflective comments can be utilized several times as a patient discusses and experiences feelings. One reflective comment may be insufficient. In fact, as a patient expresses emotional reactions, the specific feeling expressed may change in quality and degree. For example, a patient who seems sad at first may eventually express anger or frustration or vice versa. If the clinician listens carefully, the initial feeling can be acknowledged and subsequent ones reflected as they emerge.

Such attention to patients' feelings seldom requires excessive time, and may contribute to efficient interviews by removing emotional obstacles to full disclosure of symptoms and circumstances. Clinicians trained in responding to patients' feelings can have profound effects in relieving emotional distress without lengthening the medical visits. (9) If the emotional issues become too complex to address in the interview time available, you can acknowledge the significance of the feelings and make arrangements to deal with the emotional issues at a later, but acceptable date.
Alternately, a suitable other approach, e.g., a psychiatric, psychological, or social work referral, could be arranged.

## Empathy: Legitimation

Legitimation, or validation, is closely related to reflection but specifically communicates acceptance of the patient's emotional experience and respect for it. After you have carefully listened to a patient's discussion of an emotional situation, you can then let the patient know that the feelings are understandable and make sense.

Examples of validating comments would be:

- "I can certainly understand why you'd be upset under the circumstances." or
- "Anyone would find this very difficult." or
- "Your reactions are perfectly normal." or
- "This would be anxiety provoking for anyone." or
- "I can understand why you're so angry."

![Click on the picture-button on the left to see an example of legitimation.](image)

With respect to validating the feelings of someone who is angry, making a legitimizing statement does not mean that you agree with the reasons for the anger. The point is that you are trying to understand this anger from the patient's point of view.

Once you have understood the anger, you can communicate this understanding to the patient. This is sometimes difficult to do if you disagree with or feel irritated or threatened by an angry patient. Nevertheless, reflective and validating comments can play the same helpful role with angry patients as they do with sad or anxious patients.

For example, if the patient is angry because he or she has been waiting too long, you might say:

- **Clinician:** "I can see that you are frustrated because you’ve been waiting so long. I understand why you are angry. I apologize for that."

These principles are highlighted again in module 13.

## Respect

Attentive listening, nonverbal signals, eye contact, and genuine concern show that you respect your patient and his or her problems. Making explicit respectful comments further builds rapport, improves the relationship, and helps the patient cope with difficult situations.
For the purposes of this text, an intervention communicating respect refers to a specific endorsement for a specific patient behavior. Statements of respect which validate patient behaviors will, in general, tend to reinforce the behavior, i.e. make it more likely to happen again. Frequent demonstrations of respect will foster a positive relationship and promote the patients' capacity for coping.

Clinicians can usually find something to praise in all their patients. Most everyone does something well. This holds true even for patients with troubling or difficult behaviors (cf. module 13). Doctors can help their patients by focusing on one or more of their patient's successful coping skills. This will improve patient satisfaction and adherence. Examples of respectful statements would be:

**Clinician:**

"I'm impressed by how well you're coping." or
"You're doing a great job of managing your diabetes!" or
"Despite this chronic pain, you're still able to carry on at home and at work. That is quite an accomplishment."

Like all the other interventions discussed above, statements of respect must be honest, or they will be more destructive than helpful. When these sentiments reflect true feelings of the clinician, however, they are powerful facilitators of improved communication and rapport between doctors and patients.

**Comment for medical students and residents:**

Depending on your level of training, you may be aware of a “hidden curriculum”- what you learn about attitudes and behaviors toward patients from other residents and attending clinicians. Some residents and attendings may call patients names such as "gomers" or "crock." They may be abrupt with patients or avoid difficult conversations. They may not demonstrate the kind of empathy and concern that you would want to have in your relationships with patients, or that you would want for your loved ones if they were ill. Some residents and attendings will deride your interest in patients as irrelevant, perhaps describing it as “warm and fuzzy.” If you are a trainee, it is easy to fall into the rhythm of a prevalent culture, and to develop cynicism and doubt. If you practice the relationship skills in this module, and realize the value of connecting more deeply with patients; if you experience the positive effects that your skills have on your understanding of patients’ illnesses and their well-being, you are more able to withstand the pressures of the “hidden curriculum.”

---

**Personal Support**

The clinician should make explicit statements that express that he or she is there, personally, for the patient and wants to help.

This of course must be an honest statement, or it will not be effective. Statements like the following indicate personal support:
"I want to help in any way I can." or
"No matter what happens, I will be doing whatever I can to assist you." or,

**Clinician:** "The reason I'm here is because I am concerned about your health, and I want to do whatever is needed to ensure that you stay healthy," (or, "...that you recover," or, "...that you suffer as little as possible.")

The assurance of direct personal support is particularly important when situations are changing rapidly or in those situations where there is considerable uncertainty about diagnosis or treatment, or where anxiety or tension or conflict is paramount. Your statement of personal involvement means a lot, and leads to improved rapport and solidification of the doctor-patient relationship.

---

**Partnership**

Patients are more satisfied with clinicians and are more likely to adhere to treatment recommendations when their clinicians assure them that they are working in close partnership, and that the clinicians are as attentive to the patients' needs and requests as to the technological or biomedical demands of the situation.

Truly working together as partners cannot occur unless clinician and patient agree on an understanding of the task in hand. The first task is the process of the interview itself. It may sometimes therefore be helpful for the clinician to offer brief explanations in advance of certain components of the interview such as the inquiry into personal and social factors. An example might be, "It would be helpful to know a bit about your personal circumstances because sometimes this has a bearing on how best to sort out your problem." (module 5)

Increasing the participation of the patient in his or her own treatment improves the patient's coping skills and improves the likelihood of good outcome from illness processes. Clinicians' work is much easier when patients sense a clear joining together to find the best solutions, especially for thorny and difficult problems.
Physicians can promote this type of partnership, by making statements like the following:

"Let’s work together in developing a treatment plan once I have reviewed some of the options with you." or,
"After we’ve talked some more about your problems, perhaps together we can work out some solutions that may help." or,
"I’ll need your help as we go along, to be certain that I fully understand your ideas and your concerns about situations that come up--this is about your health, and I want to be sure we are working in synch with each other."

Annotated Video (not shown in print-out text)

**Behavior Checklist**

1. **Demonstrates non-verbal warmth and attentiveness**
   - Appropriate eye contact (direct eye contact most of the time)
   - Appropriate tone of voice (demonstrates concern and interest)
   - Appropriate pace of interview (not too fast or too slow)
   - Appropriate posture (generally forward lean of head and body towards patient)
   - Attentive silence

2. **Demonstrates verbal warmth and attentiveness**
   - Greeting shows genuine interest in patient as a person
   - Explain the situation
   - Summarize patient’s main concerns
   - State that patient’s concerns are your primary focus
   - Choose words that indicate concern for the patient and interest in the patient
   - Respond to emotion right away
   - Invite participation
   - Encourage participation

3. **Demonstrates specific verbal relationship responses**
   - Reflection (notice and name emotion)
   - Legitimation (validation- accept the emotion)
   - Support (direct personal offer of support)
   - Partnership (direct offer to join together)
   - Respect (specific endorsement for specific behavior or trait)
   - Interrupt silence (or factual exchange) to respond to emotion

**References**


Video (not shown in print-out text)

Rationale
by Ron Saizow, MD

Video (not shown in print-out text)
The Patient's View

Video (not shown in print-out text)
The Doctor's View
Ronald Saizow gets his thoughts together before meeting with the patient

Questions for Reflection:

1. What might keep you from allowing patients to state all their concerns at the beginning of the interview?

2. Setting a visit agenda with a patient requires organization and prioritization. How confident are you in these abilities? How could you improve these abilities in your patient interviews?

Key Principles:

1. Patients typically present with more than one concern and rarely discuss them in order of their priority.
2. You can enhance your efficiency, diagnostic accuracy, and patient satisfaction by using time-saving communication strategies to elicit a comprehensive list of the patients’ symptoms and concerns.

3. You can enhance patient participation in the encounter by facilitating the development of a mutually agreed upon agenda that includes both the patient’s and your priorities.

**Learning goals:**

Learners will implement strategies to elicit all patient concerns, and to reach agreement on collaboratively constructed visit agendas.

**At the conclusion of this module, you will be able to:**

- Discuss the importance and rationale for eliciting all patient concerns to establish, through negotiation when necessary, the visit agenda.
- Discuss and implement communication strategies at the beginning of each medical encounter to elicit a comprehensive list of patients’ concerns.
- Discuss and implement communication strategies to prioritize and reach agreement on the agenda.
- Identify personal barriers to the elicitation of concerns, and the risks of failure to do so.

**OPEN THE DISCUSSION: BASICS**

- **Introduce yourself**
  If you have not met the patient previously, it is important to introduce yourself and your role on the healthcare team, including identification as a student or resident if appropriate.

- **Allow the patient to complete the opening statements without interruption**
  Once you have asked patients about the reasons for their visits, wait without interrupting until you’ve heard the complete response.

- **Survey all symptoms and concerns before focusing on one issue**
  Patients in the ambulatory setting have an average of 3 concerns per office visit.

**Introduce yourself**

If you have not met the patient previously, it is important to introduce yourself and your role on the health care team, including identification as a student or resident if appropriate.

Patients appreciate the respect demonstrated by addressing them by their last names, and using their titles (e.g. Mr., Dr., Reverend) when appropriate. If uncertain, you can ask patients how they would like to be addressed.

If you address patients by their first names when they address you by your title, an implicit
imbalance of power is created that can affect the nature of the relationships and may convey to patients a sense of disrespect and diminishment.

If you are a medical student or resident, it is best to identify yourself as such: "Hi, I'm --------, a third year student on your medical team." "Hi I'm Dr. --------, a surgical resident. I'll talk with you about your problems and do a physical exam, and then Dr. --------, the attending clinician will be in to see you."

Allow patients to complete opening statements without interrupting

Each clinical encounter begins with the clinician’s invitation to the patient to share the symptoms and concerns. Once you have asked a patient about the reasons for the visit, wait without interrupting until you’ve heard the complete response.

Waiting until patients complete their opening statements has a number of benefits. Patients feel heard, and understand you are interested in their stories. It conveys to patients that they should do more of the talking, and may encourage them to give you a fuller account of their symptoms and concerns. It also encourages patients to express their full range of concerns, which they may not do if interrupted.

Numerous studies of medical students, residents, and experienced clinicians demonstrate early interruption by clinicians, usually within 18-23 seconds of the patient beginning their opening statement. (1,2) In the recent study by Marvel and colleagues (2), clinicians offered patients the opportunity to complete their statements of symptoms and concerns in only 23-28% of visits (2). Patients who were allowed to complete the expression of their concerns took an average of 32 seconds to do so, and interviews in which the complete agenda was solicited lasted only 6 seconds longer (2). In another recent study, patients’ mean spontaneous talking time was 92 seconds and 78% of patients finished their opening statements within two minutes (3).

Clinician interruptions and unilateral direction of the agenda may be one explanation for the findings of Stewart et al., that doctors failed to elicit 54% of patients’ reasons for coming to the doctor and 45% of their worries (4). Marvel and colleagues found that once the clinician focused the discussion on a particular concern, the likelihood of seeking additional concerns was quite low (8%) (2).

Survey all symptoms and concerns before focusing on one issue.

Patients in the ambulatory setting have an average of 3 concerns per office visit (5,6).

Survey all of the patient’s symptoms and concerns briefly at the beginning of the interview before exploring any one in depth. This habit is helpful and important in both inpatient and outpatient settings. You may assume that the patient’s first stated concern is the most important one. In fact, concerns are infrequently revealed by patients in order of their importance to them (8). They may withhold their most important concerns or emotionally laden topics until they feel they can trust you, feel confident that you really want to know their concerns, or until you bring up the topic (9).

Elstein and colleagues found, in their classical analysis of medical problem solving, that experienced, competent clinicians begin generating tentative hypotheses very early in patient
encounters from clusters of clues. They revise their hypotheses as additional information is obtained (7). Effective hypothesis generation depends on the clues obtained from the patient and how the clinician organizes and analyzes them. Therefore, an initial comprehensive survey of concerns may enhance diagnostic efficiency and accuracy.

COMMUNICATION STRATEGIES TO ELICIT CONCERNS

- **Facilitating the patient’s uninterrupted statement**
  Start with open questions to elicit, without interruptions, the patient’s reasons for the office visit.

- **Use the core skill: Ask, “What else?”**
  After the patient finishes his or her opening statement, direct the patient to state additional concerns, by asking “What else?”

- **Direct and redirect the patient to establish the full list of concerns**
  This interviewing technique requires active direction by the clinician.

- **Ask about both physical and psychosocial symptoms and concerns**
  At the beginning and throughout the medical interview, remember to elicit the patient’s concerns, fears, hopes and expectations as well as the physical symptoms that prompted the patient’s visit or hospitalization.

- **Summarize and add clinician concerns**
  Once the patient’s full list of concerns has been elicited, summarize them back to the patient to check that the list is correct and complete.

**Facilitating the patient’s opening statement**

Start with open questions to elicit the patient’s reasons for the office visit or symptoms that prompted hospitalization, such as, “What brings you in today?”

"Open" questions require explanation and elaboration. "Closed" or specific questions can be answered with yes/no, or a few words.

**Explain the process**

Explain to the patient that your initial goal is to create a full list of concerns in order to plan how best to use the time available for the encounter.

You will make a more detailed exploration of concerns after you and the patient have a chance to understand the full range of concerns. The full range will include whatever the patient says, as well as concerns that you have, which the patient may not be aware of or attuned to; such as an abnormal laboratory finding or discussion of prevention issues.

**Use the core skill: Ask, “What else?”**
Following the opening statement, you then direct the patient to state additional concerns, by asking "What else?"

You may continue prompting the patient by asking "what else" or using a class of linguistic devices called "continuers," such as "mmh", "I see" or "I understand."

Patients will often mark the end of their list of concerns by saying "That’s all." Checking with the patient by asking, "Are you sure that’s all?" or "I have the feeling that there might be something else" encourages the patient to reveal their hidden concerns and agendas.

**Direct and redirect the patient to establish the full list of concerns**

This interviewing technique requires active direction by the clinician. Patients usually begin telling the full story of each concern, instead of simply listing the name or “title” of the concern (back pain, sleep problems, etc).

Sometimes it is useful to interrupt and make a clarifying statement such as, “This sounds like an important concern to you. I will return to it but first I’d like to hear if there are any other concerns that you would like me to know about?” You may need to redirect the patient several times, and repeatedly ask “What else?,” until the patient completes their list of concerns.

You may be uncomfortable with the directiveness required in developing the list. However, patients generally wish to assist your attempts to understand their problems, and readily adapt to this method especially when it is explained in advance. Many will begin coming to subsequent visits with their lists prepared.

**Ask about both physical and psychosocial symptoms and concerns**

At the beginning and throughout the medical interview, continue your elicitation of patient’s concerns, fears, hopes and expectations as well as the physical symptoms that prompted the visit or hospitalization.

As noted previously, the first symptom or concern expressed by the patient in the office or hospital setting may not be the only one, or the most important either to you or the patient (8). Patients frequently have underlying concerns and requests which they are not comfortable divulging until they feel comfortable in the relationship with the clinician (9).

Patients are more likely to express themselves, whether during brief encounters or ongoing relationships, when you care enough to ask, listen to their responses, and indicate willingness to help or to get help for them. Examples of patients’ unvoiced agenda items include worries about possible diagnoses and illness, their seriousness and what to expect, ideas about the cause of their symptoms, side effects of treatments or medications, and social information (10). You can ask directly: "What are you most worried about," or comment on their expressed emotions, "You seem pretty upset about these symptoms." Patients’ expression of these worries and concerns may engender painful feelings such as sadness or anger. You must be prepared to attend to these emotions before completing the agenda. (module 6, "Build the Relationship" and module 9 "Understands the Patient's Perspective" explore this issue in more detail.) Sometimes patients themselves are not aware or can’t describe what’s bothering them physically or psychologically.
The untangling of the patient’s symptoms and their associated worries may emerge during the course of the interview.

If you don’t understand the full scope of reasons why the patient has come to seek medical help, you won’t be able to adequately diagnose or provide what the patient desires and needs. This may result in poor outcomes for both patient and clinician. Incomplete solicitation of symptoms or concerns is also associated with patient concerns arising late in ambulatory interviews, decreased time management efficiency (12), and failure to expose hidden agendas (13). In addition, misunderstandings and non-adherence to prescribed treatments may arise when patients’ ideas, symptoms and concerns are not fully identified (14). Patients who leave a visit with unvoiced desires and unfulfilled requests report being less satisfied with their care (15, 16, 17).

---

**Summarize and add clinician concerns**

Once you elicit the patient’s full list of concerns, summarize them back to the patient to check that the list is correct and complete.

After checking with your patient, add your own issues (e.g., your concern about a lab test or a prevention issue, or something the patient overlooked) and begin the process of negotiating and agreeing on the agenda for the encounter.

The following table lists questions and other skills that facilitate your elicitation of all patient concerns:

<table>
<thead>
<tr>
<th>Communication strategy</th>
<th>Example clinician statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask open questions</td>
<td>“What brings you in today?”</td>
</tr>
<tr>
<td>Allow uninterrupted opening statement</td>
<td>“I would like to make a list of all of your concerns before we focus on any one them.”</td>
</tr>
<tr>
<td>Explain the process</td>
<td>“I’ll get back to that.”  &quot;What else is on your list?”</td>
</tr>
<tr>
<td>Redirect</td>
<td>“What else?”</td>
</tr>
<tr>
<td>Use continuer</td>
<td>“How has this illness affected you?”</td>
</tr>
<tr>
<td>Ask about both physical and psychosocial issues</td>
<td>“Let me see if I have everything.... I also need to check on...”</td>
</tr>
<tr>
<td>Summarize patient and clinician concerns</td>
<td></td>
</tr>
</tbody>
</table>

---

**Reaching an agreement**

- **Prioritize and negotiate the visit agenda with the patient**
  Since time is usually limited, the patient and you must agree on the visit priorities and negotiate the agenda, if necessary.

- **Patient and clinician barriers to negotiating an agenda**
  Clinicians worry that eliciting all concerns is inefficient. Clinicians worry that once they name all the concerns they will have to address each one. Patients are often confused about the process, initially.
Risks of incomplete agenda setting

If you attempt to get all the issues on the agenda early, fewer patients will raise important concerns just as you prepare to conclude the interview. Time is wasted and interviews prolonged when patients bring up new concerns later in encounters. Sometimes issues of critical importance to health and to adherence, such as domestic violence, alcohol problems, lack of funds and so on never surface if agenda-setting is incomplete.

Prioritize and negotiate the visit agenda with the patient

In most clinical settings time is limited, and taking time to set an agenda results in more efficient and more patient-centered interviews.

In the outpatient setting, you must attend to acute problems, following-up on previous problems, counseling and prevention. In both ambulatory and hospital settings, you must often discuss diagnostic procedures and complex medical regimens and surgical procedures. You may have to use specific strategies to reach agreement on the agenda for the encounter depending upon the number or complexity of concerns and the time allotted for in-patient discussions or ambulatory visits (Figure 2).

Because scheduled time may not allow evaluation of every concern, it is essential that both the patient and you prioritize the concerns. Whatever concerns cannot be addressed at that time may be followed up at subsequent encounters. You may begin this segment by asking patients to rank order their top priorities among the full list of concerns elicited earlier in the discussion. At this point, you should state and explain any urgent or important biomedical or psychosocial issues you have identified during the discussion or based on additional clinical data available. If these issues could adversely impact the patient’s health and require immediate or timely attention, you must address them during the present interaction in accordance with your professional responsibility.

You can frame the process of reaching agreement on the agenda by telling patients the amount of time allocated for the encounter. This may be expressed in minutes or as a brief, intermediate, or comprehensive appointment. Time-framing is a useful strategy to help clarify what issues can reasonably be discussed in the allotted time.

Part of agreeing on an agenda is to "flag" some issues for follow-up at subsequent scheduled visits. When you are explicit about this process, you indicate to patients that their concerns have been heard and will be systematically addressed over time.

Figure 2. Reach agreement on the visit agenda

**Communication strategy** | **Example clinician statements**
--- | ---
Ask patients to state their priorities | “Among your concerns, what are your highest priorities today?”
State urgent clinical issues as priorities | “I am quite concerned about your blood pressure of 200/100 which I think we must address today.”
State time available | “We have 15 minutes (or intermediate visit) today. Which of your priorities did you want to be sure we addressed today, given the time available?”
Reach agreement and summarize | “Let’s start by talking about our two top priorities: your blood pressure and your sleep problems.”
Reassure that other concerns will be addressed later. | “We can address the remaining concerns at the next visit.”
Patient and clinician barriers to negotiating an agenda; risks of incomplete agenda setting

Clinicians often believe they have no time or insufficient reason to elicit all patient concerns and negotiate a mutually agreed upon agenda. Research suggests that careful agenda-setting improves efficiency, diagnostic accuracy, and patient satisfaction.

Patients allowed to complete their list of concerns usually take only 32 – 150 seconds to do so (1-3). A comprehensive initial survey improves efficiency, as it diminishes the likelihood of hearing about important new issues (like chest pain) late in the interview, just when the visit seemed about to end (1,2). Such late arising concerns frequently prolong medical encounters. The elicitation of all concerns reduces the frequency of late arising concerns by more than half (34.9% vs. 14.9%) (2).

You enhance diagnostic accuracy by surveying patients' concerns and reaching agreement on priorities. Patients' initial complaints may not predict the problems truly important to them, according to research that ranked problems after encounters were finished. Burack and Carpenter showed that the patient’s chief complaint predicted the patient’s primary problem only 6% of the time for psychosocial problems, and 76% of the time for biomedical problems (18).

Many clinicians shy away from eliciting and hearing numerous patient concerns, because they feel compelled to do something about each one, or because they don't feel comfortable responding to patients’ emotions. Patients often simply want you to hear and understand their concerns, not necessarily to act upon them (8). The concerns that do require further attention may be dealt with in subsequent visits.

Patients are often confused by the interruptions and redirecting of clinicians when initially participating in this process. They respond very positively to compassionate explanations, such as the following: "I see from your reaction that this seems a bit odd or confusing, but I am very concerned and want to make our time together as effective as possible in meeting your needs." and, "Many of my patients did not like this work at first, but setting the agenda has helped us work very well as a team."

CONCLUSION

Patients usually present to primary care offices with an average of three concerns.

Elicitation of all of the patient’s symptoms and concerns in the ambulatory and in-patient setting requires little additional time and diminishes the likelihood of late arising concerns or hidden agendas. In addition, this strategy may enhance diagnostic accuracy.

You can use the strategy of beginning with an open question and allowing patients to complete their opening statements without interruption to begin the elicitation of a comprehensive list of symptoms and concerns. You can then use continuers, such as "what else?" and direct patients to provide a complete list of concerns before discussing any one issue in depth. You include your agenda items and use the strategies of time-framing and priority negotiation to establish the visit agenda. In this manner, you can efficiently establish a realistic, prioritized agenda for the visit. Remaining concerns can be attended to in scheduled continuity care visits.
Clinicians who explain this process at the beginning of the visit and reach agreement about a mutually constructed agenda enable patients to collaborate and participate in their care.

**BEHAVIOR CHECKLIST**

- Begins by asking open questions about reasons for the encounter
- Allows patient to complete opening statements without interruption
- Informs patient of need to elicit full set of concerns
- States time available
- Asks “what else?” or “Is there anything else?” to elicit full set of concerns
- Redirects, “I’ll get back to that,” until all concerns identified
- Asks about both biomedical and psychosocial concerns
- Summarizes list to insure completeness
- Adds clinician’s concerns to the list
- Asks patient to clarify priorities
- Explains need to address urgent clinical issues
- Engages patient in reaching agreement on agenda
- Reassures that unaddressed issues will be followed up

**REFERENCES**


3. Langewitz W, Denz M, Keller A, Kiss A, Ruttimann S, Wossmer B. Spontaneous talking time at start of consultation in outpatient clinic: cohort study. BMJ. 2002; 325:682-683. [Free online full text article in BMJ](https://www.bmj.com/content/325/7378/682) available


10. Barry CA, Bradley CP, Britten N, Stevenson FA, Barber N. Patients’ unvoiced agendas in
Welcome to DocCom Module 8: Gather Information

by Beth A. Lown, MD
Rationale

by Beth A. Lown, MD

You greatly improve your patients’ outcomes when you jointly construct the story of the illness, weaving the patient’s elaboration of the biomedical and psychosocial threads together with your own hypotheses.

The primary goals of information gathering are to elicit biomedical and psychosocial information in order to generate clinical hypotheses, and to understand the context and impact of the patient’s illness while continuing to build the patient-doctor relationship.
The Patient's View

Questions for Reflection:

1. What attitudes, thoughts and behaviors enable you to really listen to another?
2. What attitudes, thoughts and behaviors impede your ability to really listen to another?
3. How do people know when you are not only listening to them, but also understanding them?
4. What are your skills in facilitating patients' telling their stories of illness?
5. What attitudes and skills do you need to learn or improve that would enhance your ability to interview patients?

Key Principles:

1. The key to effective information gathering is seeking to understand the details of patients' symptoms in their psychosocial and emotional contexts.
2. Communicating an understanding of the patient’s experience and concerns is associated with improved clinical outcomes.
3. You can maximize your efficiency by using specific interviewing strategies, such as active listening, open and closed questions, clarifying, summarizing, and transitioning.
4. You can encourage active patient participation and improve clinical outcomes by sharing control of discussion topics and talk time during interviews.
5. You can understand patients’ concerns and emotional reactions to their symptoms by asking directly, and by exploring and responding to their verbal and nonverbal clues.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe the primary goals of relationship-centered information gathering.
- Describe and demonstrate relationship-centered strategies for gathering information.
- Describe and demonstrate strategies for encouraging patient participation in gathering
Use your knowledge and skills to gather information effectively from a patient.

INTRODUCTION

You can greatly improve your patients’ outcomes when you jointly construct the story of the illness, weaving the patient’s elaboration of the biomedical and psychosocial threads together with your own hypotheses.

The medical encounter begins when two people enter into a relationship with hopes of understanding, help, and healing. One of the major functions of all medical encounters is the development of a relationship between the clinician and patient that enables them both to realize these hopes.

Skillful clinicians efficiently gather accurate biomedical and psychosocial information to generate hypotheses about possible causes of the patient’s symptoms, while gaining an understanding of the patient’s experience of illness. They listen for and develop the “narrative threads,” (1) or subplots and clues about the patient’s disease and the personal meaning of illness, weaving them together into the tapestry of the clinical history.

This approach combines the patient’s voice with the clinician’s elaboration of the medical details. The result is a jointly constructed story that integrates the world of the clinician and the world of the patient.

The primary goals of relationship-centered information gathering

The primary goals of information gathering are to elicit biomedical and psychosocial information in order to generate clinical hypotheses, and to understand the context and impact of the patient’s illness. Your skills in accomplishing these goals will help you to build a more effective patient-doctor partnership.

These goals are accomplished when the clinician:

- Has a sufficient medical knowledge base.
- Values the importance of understanding the patient as a person as well as the patient’s disease processes.
- Efficiently pursues critical information and clues about the biomedical, psychosocial, and subjective aspects of the patient’s symptoms and illness.
- Encourages the patient’s active participation in exploring medical and psychosocial information.

These goals and premises form the foundation of a relationship-centered approach to communication and care (2).

We call this a relationship-centered approach because it combines the expertise, values and needs of the patient with those of the clinician.
Information gathering skills and outcomes

Patients who feel they have been able to fully express their symptoms, concerns, opinions, and questions have more symptom resolution, less role and physical limitations, improved functional status, and improved health outcomes such as blood pressure and blood glucose level.

Communication training designed to enhance clinicians’ understanding of the patient as a person and ability to share control of the medical encounter by encouraging the patient’s participation, can lead to significant improvement in these interviewing skills and result in increased patient satisfaction.\(^3\)

Patients’ anxiety and symptoms are reduced when clinicians are trained to ask about patients’ understanding of the nature and impact of their problems as well as their concerns and expectations.\(^4,5\) Research by Roter et al. showed that skills training designed to teach clinicians to delineate the patient’s problem by starting with open-ended questions, using facilitative statements to help patients tell their stories in their own words, and assessing the effect of the patient’s problem on psychosocial functioning did not increase length of visits, and reduced patients’ emotional distress.\(^6\)

Patients who feel they have been able to fully express their symptoms, concerns, opinions, and questions have more symptom resolution, less role and physical limitations, improved functional status, and improved health outcomes such as blood pressure and blood glucose.\(^7,8,9,10\) These studies support the goal of teaching clinicians to share control of the discussion and to facilitate patients’ talking about their concerns and the impact of illness.

Primary vs. secondary sources of information

When time is short, relying on the “old chart,” is tempting. Secondary information may be helpful or inaccurate, and can never supplant a personal interaction.

Before we begin to discuss how to gather information, let’s consider the validity of the various sources from which clinical histories are obtained. This may sound obvious, but whenever possible, you should elicit the patient’s story directly from the patient. In the clinical years of training, you often read or hear a snapshot of the patient’s history from a triage nurse, a house officer, or the patient’s old medical record before speaking with the patient. It’s tempting to rely on the summaries of others, or to rewrite previous histories from the “old chart” especially when time is short. Secondary information is often quite helpful, but may be incomplete, inaccurate or biased.

It’s important to formulate your own independent opinion about the patient’s situation based upon primary data; your interview with the patient, his or her family, or caretakers.

Organize the interview flow in the time allotted

Learn and practice strategies for coping with time limitations.

There is evidence that the duration of the average U.S. office visit has actually increased, from about 16 minutes in 1989 to 21 minutes in 2005. However, the number of issues addressed in primary care visits has increased to a greater extent than has visit duration, resulting in less
available time to address individual problems.(11, Abbo ED, Zhang Q, Zelder M, Huang ES. The increasing number of clinical items addressed during the time of adult primary care visits. J Gen Intern Med. Dec 2008;23(12):2058-2065.)

We can enhance our time management by using an organized approach to new patient and health maintenance visits, and by trying to establish the agenda and goals of a visit early in the encounter (Module 7).

This does not mean, however, that we must stick to a rigid format or agenda. On the contrary, relationship-centered interviewing requires flexibility as the clinician continues to elicit and respond to the patient’s symptoms, concerns and needs throughout the interview. The process of exploring the patient’s history as it unfolds, agreeing on the goals of the visit, redefining them when new problems arise during the conversation, letting the patient know how much time is available, and explaining transitions between topics are all helpful and respectful strategies for efficient time management.

Understand the “Chief Complaint” and expand the “History of Present Illness” (HPI)

Thoughtful attention to story elements enables you to decide which hypotheses and ideas you should probe to the fullest extent.

The medical interview begins with the elicitation of the patient’s primary symptoms and concerns. This has traditionally been called the patient’s “Chief Complaint” or reason for admission when speaking with hospitalized patients. It is usually the answer to the question, "What brought you to the hospital?" or, “How can I help you today?” Ambulatory patients may come to the office with one or several acute, subacute or ongoing problems. Furthermore, as we learned in module 7 "Open the discussion," patients may not always tell their clinicians their underlying “Chief Complaint” right away, especially if their primary concern is psychosocial rather than biomedical.(12)

Once the clinician has elicited the patient’s concerns, the interview proceeds with an inquiry into the agreed upon agenda items. In hospitalized patients, the clinician surveys all of the patient’s concerns and symptoms in a similar fashion before exploring any particular symptom in depth during the exploration of the “History of Present Illness.”

The “History of Present Illness,” (HPI) or description of the patient’s current symptoms, is one of the most difficult and important aspects of the patient’s story. All of the information needed to formulate and test hypotheses about the patient’s disease and the psychosocial context of the patient’s illness must be elicited whether the patient is in the hospital or in the outpatient setting. The patient’s diagnostic evaluation and subsequent treatment plan is based on the “HPI”. Therefore, it’s important that the HPI be elicited carefully in detail, and presented clearly to others.

COMMUNICATION SKILLS that improve information gathering

Practice and utilize these skills, and your competence at information gathering will steadily improve.

Clinicians use many different communication skills to gather information effectively and efficiently. In this section we will focus on 6 skills:
Use an open to closed question strategy

Start interviews with open questions, because patients respond by revealing relevant (often surprising) information more readily than to closed questions.

Develop the timeline of the illness

Ask patients to tell you the story of their illnesses from the beginning, and facilitate their story telling until you understand how an illness progressed from the onset until the present.

Characterize symptoms

Learn to ask for all the details about key symptoms in the patient’s story.

Listen actively on multiple levels

Practice “listening on multiple levels;” use verbal and nonverbal encouragements for your patient to speak, and use silence effectively.

Clarify meaning

Clarify important words that may have different meanings for you and for your patient.

Summarize

Summarize, to communicate your attentiveness, to encourage your patient to clarify and to discover any gaps in understanding.

Redirection and transitions

Respectfully guide the interview by redirecting the patient and by using transitional statements.

---

Use an open to closed question strategy

Begin with open questions

Start interviews with open questions, because patients respond by revealing relevant (often surprising) information more readily than to closed questions.

Effective interviewers begin with open questions until they have an overview of the patient’s story. Open questions require some explanation or description. They cannot be answered with single words or yes/no responses. You might tell the patient that you would like to hear a brief summary of what happened before you begin to ask detailed questions. You can elicit much of the content of the HPI using this open-ended method of questioning.

Open questions reveal substantially more relevant information than closed questions and are therefore a more efficient way to begin the interview. Patients are the only true experts on what has happened to them. You can ask an endless series of closed or specific questions to try to get closer and closer to their experiences, but it’s faster and simpler to just ask patients to describe it for you. A “high control,” closed questioning clinician style can result in an incomplete database.

For example, let’s suppose a patient says she has chest pain. If your next question is, “Is it sharp or dull?” the patient may assume she has to pick one of these adjectives, which may not accurately reflect her physical sensation at all. Or, she may say, “neither,” leaving you in the position of having to present several alternative description choices until it is closer to her experience. You might need to ask a multitude of closed questions to accurately understand the series of events or physical sensations the patient has experienced, which is an inefficient use of time.

Two types of open questions
There are two types of open questions: general open questions, and focused open questions. You use general, open questions to begin an inquiry when the territory or range of concerns is unknown. This type of question allows patients to begin their stories at the point that feels most important or most comfortable. Focused, open questions allow patients to continue to unfold their stories, but on a focused topic of interest to the interviewer.

**General, open question:** “Can you tell me what brings you in today?”

**Focused, open question:** “Can you tell me more about your chest pain?”

**Use closed questions to probe details**

Once you have asked enough open-ended questions to elicit an overview of the patient’s story, you can then ask specific or closed questions to better characterize the symptoms, probe the details and facilitate hypothesis testing. For example, if the patient feels ill and has been coughing, you might be considering respiratory infections. It would be important to ask specific questions such as, “Have you had any fever?” or “Are you bringing up any sputum?”

**Use an open to closed question strategy**

Experienced clinicians weave open and closed questions throughout the discussion of the HPI. (15)

They may explore physical sensations or events with general, open questions for as long as it takes to understand an overview of the patient’s story. They use focused, open questions to explore a particular symptom and to form some hypotheses about disease processes. They then ask, “anything else?” repeatedly, to give the patient a chance to mention other associated symptoms and concerns, until the patient says something like, “no, that's all.” They then transition to closed questions to elicit specific details in order to test hypotheses and to see if the patient’s symptoms are consistent with a particular disease or syndrome. (16)

Check out the video example about "open to closed question strategy" on the left.

During the interview they may realize a point or discover a symptom that requires further clarification, or challenges their hypotheses, and explore this with open questions until they understand more, then switch to specific questions to clarify further. This process proceeds from open to closed to open to closed questions until all major symptoms have been explored, one or more hypotheses generated, and supporting or negating evidence elicited. Thus, they weave information into a constructed tapestry that blends the threads of the patient’s story with the clinician’s thought processes and clinical reasoning.

**Develop the timeline of the illness**
Ask patients to tell you the story of their illnesses from the beginning, and facilitate their story telling until you understand how an illness progressed from the onset until the present.

**Every story has a beginning, a middle, and an end.** Eliciting an accurate chronology helps patients organize their stories of illness, and often gives clues to underlying disease processes and contributing psychosocial factors.

![Image](image_url)

**Check out the video example** about "developing the timeline" on the left.

When does this patient’s story truly begin? Try asking the patient these questions:

- **Beginning questions:**
  - “Go back to the beginning. What was the very first thing you noticed that felt unusual or different?”
  - “When did you last feel well?”

- **Middle questions:**
  - “How did your symptoms change over time?”
  - “What happened next?”

- **End questions:**
  - “Have you experienced anything similar in the past?”
  - “What finally prompted your seeking attention now?”

How did the story evolve over time? How does the story end in the patient’s current condition?

Trace the chronological unfolding of the story over time by asking: “What happened next?... and then what happened?” until you have elicited and heard a blow-by-blow description.

**The key skill in developing the timeline is asking “what happened next?”**

---

**Characterize symptoms**

Learn to ask for all the details about key symptoms in the patient’s story.

Several important aspects of symptoms must be characterized in order to generate hypotheses about their cause and treatment.

- **General and specific context of symptoms**
- **Story timeline** - see above chapter "Develop the timeline of the illness"
- **Quality of symptoms**
- **Aggravating and relieving factors**
- **Location and radiation of pain if present**
- **Severity**
- **Frequency or quantity, and duration** (with example video)
- **Associated symptoms** (with example video)
Impact and meaning of symptoms to the patient

The general and specific context of the symptoms

The general context of symptoms is the background within which the HPI occurs and develops. Who is this patient? What is going on in his or her life at the time the story begins and evolves? What are the psychosocial and physical factors that may be playing a role in the patient’s illness?

Alan R’s chest pain:
Alan R. is a 52 year old accountant who came to the emergency department in early April for evaluation of chest pain. The morning of this episode, the patient learned that his sister-in-law, who had been battling metastatic breast cancer, had died leaving behind his brother and their two teenage children. Mr. R. had been under a good deal of stress at work, working long hours as it was approaching the income tax deadline for his clients.

The specific context contains the details of what is happening in the patient’s life and immediate surroundings at the time of acute onset of symptoms.

Alan R’s chest pain (cont.):
The patient drove to his brother’s home and parked at the bottom of a hill. As he dashed up the hill, he began thinking about the grief and distress he would soon encounter. He noticed the sudden onset of discomfort beneath his breastbone which increased in intensity as he approached his brother’s apartment house.

Quality of symptoms

Try to imagine what the patient’s symptoms might feel like. Ask about their quality as if you were going to write a short story about the symptoms.

The most important aspect of a patient’s physical symptoms is its quality. What exactly is the patient trying to describe to you? As you progress through training, you develop an expanding databank of experience regarding how various diseases present. A patient’s description of various symptoms then triggers associations with specific disease entities, and guides hypothesis generation, which in turn directs further inquiry. Students and clinicians in training might try a strategy for understanding clinical symptoms that I call the use of “somatic imagination.” Try to imagine what the patient’s physical symptoms might feel like as if experiencing them yourself. If you can’t imagine experiencing the symptoms yourself well enough to describe them clearly to a friend, ask more questions.

Don’t offer patients descriptive adjectives before eliciting theirs. Ask patients to describe the quality of their symptoms until they have exhausted their descriptive vocabulary. It is important to really listen to the words patients use to describe their symptoms, and use those words when reflecting back to the patient. If the patient speaks of “a pressure,” do not then say something like, “so did this pain radiate anywhere?”

Aggravating or relieving factors

Inquire, “What makes the symptom better, (or worse).”

Ask patients what makes their symptoms better (palliation) and worse (provocation). Ask if there were any triggers that initiated the symptoms. Triggers and aggravating and relieving factors will give diagnostic clues. After asking in an open-ended way, you should ask questions that relate to your differential diagnoses: Did cold air trigger the patient’s wheezing and shortness of breath?
Was there any relationship between the time the patient began taking anti-inflammatory medicines and his epigastric pain? What happened to the patient’s calf pain when he stopped to rest?

The answers to many of these questions yield important clues about diagnoses.

- **Location and radiation**

  Find out exactly where the symptom is, and where it goes.

If the symptoms are localized to a particular area of the body, ask patients to indicate exactly where they are experiencing them. Generalized or systemic symptoms such as fatigue and malaise cannot be localized, but can be characterized using the other descriptors indicated. Some symptoms have characteristic patterns of radiation or representation in areas of the body other than their site of origin, such as the left arm and jaw discomfort associated with chest discomfort from coronary ischemia, or posterior leg pain from sciatic nerve impingement.

**Alan R’s chest pain (cont.):**

Mr. R had difficulty finding words for the sensation he had experienced as he was dashing up the stairs to his brother’s apartment. It wasn’t painful exactly, but rather a sense of an increasingly oppressive, diffuse sense of substernal and left sided chest pressure, “as if a great weight had been placed there and was squeezing the breath out” of him. He had no discomfort elsewhere.

- **Severity**

  Ask about the severity of the symptom.

Characterizing the severity of symptoms helps the clinician understand their cause, significance, and the urgency with which they must be attended. The “crushing” substernal chest pain of myocardial infarction, or “thunderclap” headache of subarachnoid hemorrhage are classical descriptions of problems requiring urgent attention. Many clinicians ask patients to rate pain symptoms on a scale of 1 to 10 with 10 being the most severe. This is helpful to follow the progress of symptoms and efficacy of therapy.

- **Frequency or quantity, and duration**

  Ask patients how often they experience the symptoms, and how long they last.

Quantification of the number of episodes of a given symptom within a specified time period is also important, such as number of diarrheal stools per day, or number of episodes of chest pain weekly. Progression of physiologic and functional impairment can be tracked over time by quantifying symptoms such as number of blocks the patient is able to walk before the leg pain of peripheral vascular disease (claudication) sets in; or number of stairs the patient with congestive heart failure is able to climb before stopping to catch her breath.

The duration of symptoms also provides clues about diagnosis and severity. An anginal episode seldom lasts longer than a few minutes, so it's less likely to be angina if a patient says the chest pain lasted "all day." Or, a major depressive episode may be diagnosed if depressed mood persists along with other features for a 2-week period or more.
Check out the video example about "characterizing symptoms" on the left.

- top -

**Associated symptoms**

Be diligent in discovering associated symptoms to help you test hypotheses.

Once you understand the quality and evolution of the patient’s symptoms over time, you begin to generate some preliminary hypotheses about their etiology. Your knowledge of the presentation of the diseases in your differential will guide your questioning about associated symptoms. This will help you to either support or set aside a particular hypothesis. For example, in the case of Alan R, you would ask if he experienced any nausea or sweating, since these symptoms are associated with myocardial infarction. You would also ask symptoms associated with panic disorder, and might ask about symptoms associated with reflux esophagitis, costochondritis, and other diagnoses that can cause chest pain.

Check out the video example about "exploring associated symptoms" on the left.

- top -

**The impact of symptoms**

Find out about dysfunctions, disabilities and adaptations the patient makes because of the symptoms.

You should ask, “how have these symptoms affected you?” If the patient is having acute symptoms, what functional and psychological effect are they having? Did the patient fall over, double up in pain, have to sit or lie down, go the emergency room, call family members? Was the patient frightened, puzzled, concerned, terrified? If the symptoms are subacute or chronic, why is the patient coming to see you now? The patient’s answer to this question often uncovers hidden anxieties or new interpretations about the meaning of previously tolerated symptoms.

If the symptoms are chronic, what adaptations has the patient had to make? What is the functional impact of illness on daily activities? Can the patient dress, feed, bathe, go to the toilet, transfer from bed to chair, from chair to standing, pivot, walk independently, drive, shop, handle
finances, do errands such as purchasing medications? What equipment is necessary at home? What losses has the patient suffered because of illness? Has the patient had to grieve or adjust to the loss of a vocation, a job, support networks and friends because of functional impairment or disability? How has the illness affected others important to the patient?

**Alan R’s chest pain (cont.):**
When he reached the top of the stairs, Mr. R. stopped to catch his breath and rang the bell to the apartment. His brother opened the door. His other siblings and his mother had already arrived. The children had not yet returned home from school. He was relieved that his brother seemed calm and that the family was on hand to lend support. He sat down to rest. His chest pain gradually began to subside and was gone within 20 minutes. In retrospect, he vaguely recalled an episode of chest discomfort a few weeks prior after an argument with his boss. It had not been as severe and had lasted only a few minutes. He had ascribed it to “indigestion” at the time. He described his symptoms to his family who called an ambulance to bring him to the Emergency Department for evaluation.

**Much of the HPI and symptom characterization can best be elicited and explored with these questions:**

<table>
<thead>
<tr>
<th>Symptom Characterization</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context of symptoms</td>
<td>&quot;What was going on in your life when this began?&quot; &quot;How did this all start?&quot;</td>
</tr>
<tr>
<td>Illness timeline</td>
<td>&quot;Can you start at the beginning and tell me how this unfolded?&quot; &quot;When were you last feeling well?&quot; &quot;What happened next?&quot;</td>
</tr>
<tr>
<td>Quality of symptoms</td>
<td>&quot;What did that feel like to you?&quot;</td>
</tr>
<tr>
<td>Aggravating, relieving factors</td>
<td>&quot;What makes it better or worse?&quot;</td>
</tr>
<tr>
<td>Location, radiation</td>
<td>&quot;Exactly where do you feel it?&quot; &quot;Does it go anywhere else?&quot;</td>
</tr>
<tr>
<td>Severity</td>
<td>&quot;Can you rate the severity on a 1 to 10 scale, with 10 being the worst you can imagine?&quot;</td>
</tr>
<tr>
<td>Duration</td>
<td>&quot;How long does it last?&quot;</td>
</tr>
<tr>
<td>Frequency</td>
<td>&quot;How often does it occur?&quot;</td>
</tr>
<tr>
<td>Associated symptoms</td>
<td>&quot;Can you describe any other physical sensations you had when this all began?&quot; &quot;What else were you feeling?&quot; &quot;Did you notice any...(based on hypotheses).&quot;</td>
</tr>
<tr>
<td>Impact of symptoms</td>
<td>&quot;What did you do when you experienced these symptoms?&quot; &quot;How have you adapted to this illness?&quot; &quot;What was it that made you decide to come in today?&quot;</td>
</tr>
</tbody>
</table>

- top -

**Listen actively**

Practice “listening on multiple levels;” (17) use verbal and nonverbal encouragements, and
use silence for its facilitative and therapeutic effects.

Active listening is an acquired skill that involves “listening on multiple levels,” (18) the active use of verbal and nonverbal encouragements to speak, and the facilitative and therapeutic use of silence.

Clinicians learn to “listen on multiple levels.” We listen to the gestalt and the details of the patient’s story as well as its emotional and practical impact on the patient. We learn to listen to and interpret “paralanguage,” the pauses, pace, pitch and volume of patients’ conversations. The rising pitch and volume of an anxious or angry patient tells us as much as their words. We can also learn to “listen” to ourselves and our internal reactions to patients. Our own reactions are often helpful mirrors of the patient’s state of mind. Our personal experience of helplessness or sadness while listening to a patient, for example, clues us into a possible diagnosis of depression. While we are listening and trying to understand and imagine patients’ experiences, we are formulating hypotheses about the patients, their diagnoses, their emotional states, and what we will need to do next. One of the challenges of clinical listening at multiple levels is retaining the ability to focus on the patient’s experience, remaining “present” with the patient while balancing all of the other intellectual tasks of doctoring. This is a difficult and important skill which requires continuous practice and professional commitment.

Nonverbal and verbal encouragements of speech, such as head nods and “uh hm” are important ways to facilitate the patient’s expression. Another aspect of active listening is the intentional use of silence. This can be difficult, especially for students and residents. We are trained to problem solve, to take action, to intervene. Yet, there are times when sitting quietly with a patient, especially during emotionally difficult moments, communicates powerfully that we are listening, that we can hear what they have to say, that we respect them, that they can go on with their stories. Your attentive and respectful silence can be a potent therapeutic intervention.

Clarify meaning

Clarify important words that may have different meanings for you and for your patients.

Both open and closed questions can be used to clarify unclear words or statements. It’s astonishing that one word can have so many meanings for different people. For example, the word “dizzy” is used by patients to describe many different sensations including a swirling feeling as if one just flew off a merry-go-round, a sensation associated with dimming or tunneling of vision just before blacking out, blurry vision, trouble concentrating, nervousness or anxiety, fatigue, difficulty with balance, and a host of other meanings. Each of these sensations has different clinical implications. If you aren’t clear about what patients are describing, ask them to clarify.

Check out the video example about "clarify meaning" on the left.

Examples of clarification:

“I’m not sure I understand exactly what happened. Can you go back to when you were
climbing the stairs and...”

“What do you mean by stressed? Can you tell me what has been stressful?”

“The word ‘dizzy’ means different things to people. What do you mean when you say, ‘dizzy’?”

---

**Summarize**

Summarize, to communicate your understanding of the patient's story, and to encourage your patient to clarify and fill in any gaps.

When you feel you understand a patient’s history of illness, you can tell the patient you would like to summarize and would like the patient to correct any inaccuracies or omissions. Summarizing out loud reveals the gaps in your understanding. It’s a good way to check on the spot for internal consistency, flow and logic. Patients appreciate accurate summaries because it indicates good listening. It also gives the patient a chance to correct any misunderstandings and to expand the story if need be.

Check out the video example about "summarize" on the left.

---

**Alan R’s chest pain (cont.):**

Doc: “I’d like to summarize what I’ve heard you say so far. Tell me if I’ve left out anything.”

Alan R: “Sure.”

Doc: “You were rushing up a hill to your brother’s home when you developed some pressure, like a weight on the left side of your chest, which made it difficult for you to catch your breath. This lasted about 20 minutes until you were able to sit and rest and then the symptoms subsided completely. In retrospect, you may have had something similar a few weeks ago during an argument with your boss. All of this occurred while you were really upset over the death of your sister-in-law and concerned for your brother, in addition to your stress at work.”

Alan R: “Yes, that’s right.”

---

**Redirection and transitions**

Respectfully guide the interview by redirecting the patient and by using transitional statements.

You can use verbal redirections and transitions as respectful bridges to biomedical or psychosocial issues. When you “announce” your transitions, or explain your thought process to the patient, you take the patient along on the path of inquiry. The patient is more likely to feel respected and included as a partner rather than the subject of a clinician-driven agenda.
Sometimes you will decide to make a transition in the conversation. You may wish to further explore a symptom, or to change topics because time is limited, or to interrupt your patient who is talking about a subject not directly related to the present situation, or to explore remaining important psychosocial topics. At times when you wish to respectfully redirect the conversation, it is helpful to explain what you’re doing and why.

**Examples of redirection and transitions:**

“I would like to hear more about this, but in order for us to decide what to do next about your cough, I’ll need to ask you a few more questions. O.k.?”

“I’d like to move on now to ask you about your past medical history.”

**COMMUNICATION SKILLS that encourage patient participation**

Verbal dominance, a narrow biomedical focus, interruptions, and a barrage of closed or leading questions tend to consolidate clinicians’ control of medical interviews with the potential sequelae of incomplete data collection, inefficiency, and lower patient and clinician satisfaction. (19-27)

Sharing control of talk-time and discussion topics, avoiding interrupting the patient, and encouraging patient participation in discussions will improve data gathering and patient satisfaction. You are also more likely to understand your patient better and feel more satisfied with your interview. The initial minutes of interviews communicates to patients how you want the interview to go. If you start interviews with open questions, really listen to your patients, and encourage them to tell their stories, you are conveying to them that you want them to fully express themselves. If you interrupt patients early on, and ask many closed questions, you are conveying to patients that you are the one in charge and expect brief answers. You are then likely to continue a doctor-centered interview, since this is what you set up.

- **Share talk time**
  Avoid verbal dominance and high conversational control. Adjust your conversation style so it remains personal, collaborative and effective with distressed and suffering patients.

- **Integrate bio-technical with psychosocial and affective issues**
  Help patients expand their story-telling; open the windows of opportunity to fully appreciate the stories’ complexity.

- **Elicit and explore clues**
  Learn and practice the *Elicit, Explore, Acknowledge and Respond* tactic.

- **Respond to important clues**
  Practice and become adept at responding to clues and feelings in real time

**Share talk time:**

Avoid verbal dominance and high conversational control
Studies show that many clinicians flaunt the usual social rules of conversation, like, "Take turns and don't interrupt!" in interactions with patients. Clinicians often speak more than patients and control the topics of conversation (20), rather than sharing the discussion by using communication strategies that are relationship-centered, and by including topics important to the patient.

**Interruptions are one way in which a speaker gains control over conversation.** (21) Some interruptions are unavoidable, and some may be beneficial, as when patients interrupt to offer new information, or clinicians interrupt to redirect a patient on a tangent. Use of interruptions must be tempered by respect, a sense of partnership, and awareness of their consequences.

Asking a barrage of closed questions, using medical jargon, asking leading or negatively phrased questions ("You don’t have any chest pain, do you?") create an atmosphere of high clinician control. This tends to diminish patients’ willingness and ability to speak. Asking a string of questions often baffles patients. A common version of this is, “Do you have any chest pain, palpitations, or shortness of breath?” If the patient replies no, the clinician doesn't know for sure if the response applies to one or all of these symptoms.

Beginning students will often also adopt a high control style in their anxiety to elicit information from patients. However, it is important to remember that most patients will want to tell their stories, if you will let them. It is best for many reasons to let patients do a good deal of the talking. You can accomplish this using the open to closed cone strategy, including using "continuers," such as "anything else?" "uh huh," and "can you tell me more?" to facilitate patients' telling their stories.

---

**Integrate biomedical with psychosocial issues**

Help patients expand their story-telling. Open windows of opportunity to fully appreciate the complexity of patients' stories.

**When primary care clinicians focus narrowly on biomedical topics, they dampen patients’ expression and there is minimal exchange of psychosocial information.** (19)

In a study of over 100 primary care clinicians and over 500 or their patients, a narrowly biomedical, clinician-dominated communication pattern was the most common pattern, and was associated with the lowest satisfaction ratings by both patients and clinicians. Patients appreciate clinicians who integrate psychosocial with biomedical topics, share talk-time and are less verbally dominant. (34)

**In general, patients don't distinguish the biological and emotional components of their symptoms.**

Patients present with symptoms that comprise an illness, and we as their caregivers often then search for clues to underlying diseases. As we learned in earlier modules, though, patients' experiences of symptoms are affected by personality, past experiences, fears, and expectations. Interviewers who focus on the medical details to elaborate a differential diagnosis may unconsciously filter out patients’ comments about their worries or the meaning of their symptoms, and then miss the “windows of opportunity” into the heart of the patient’s hopes and fears. (22)

All the available studies emphasize that patients’ symptoms and outcomes improve, patients’ psychological distress diminishes, and both clinicians and patients feel more satisfied when clinicians ask about both psychosocial and biomedical problems and encourage patients to participate in these discussions. (23,24)
Elicit and explore clues

Learn and practice the *Elicit, Explore, Acknowledge and Respond* tactic

A strategy helping clinicians gather and integrate psychosocial with biomedical information during interviews is to use repeating cycles of: Elicit, Explore, and Acknowledge/Respond. (25,26)

1. Elicit and listen actively for clues about psychosocial and emotional concerns.
2. Explore clues by anchoring questions and statements in what’s just been said.
3. Acknowledge and respond to clues about topics important to the patient.

A minority of distressed patients reveal their most significant psychosocial concerns during the opening segment of an interview. Most patients who disclose such concerns do so later in the medical encounter, and usually only in response to an explicit inquiry. (27)

Just as you continue to construct the patient’s history of symptoms and your hypotheses throughout an interview, continue to build an understanding of the patient’s psychosocial issues and concerns throughout the interview. You will be more efficient if you check on patients’ concerns throughout the interview than if you wait until the interview is closing. (28,29)

**Sample questions/statements to probe for psychosocial and emotional issues**

“What other concerns do you have?”

“Was there anything else you wanted to mention?”

"You looked upset when you mentioned your father."

“Can you tell me what concerns you most about these symptoms?”

Patients seldom express psychosocial concerns directly. Rather, they embed “clues” about the rest of their lives, their worries, and their expectations as they tell about their symptoms. One study about these clues categorized the findings as follows: statements involving: projection or denial of feelings and concerns ("I’m not really worried but my wife keeps nagging at me to get this checked out."); vivid symptom descriptions (“This pain is torturing me like an executioner!”); attempts to explain (“I’ve been wondering if this rash is from something I ate.”); loaded statements or questions (“I hear this pill you’ve given me can cause breast cancer.”); and behavioral clues (e.g. patients who go for multiple opinions, or don’t follow through on treatment plans).(30) Many primary care clinicians and surgeons (31) do not regularly pursue these clues, and fail to acknowledge patients’ feelings.(32) Visits with these missed opportunities are longer than visits in which clinicians were responsive, so exploring clues may actually enhance efficiency in the interview. (25)

Conversation that sounds logical to the clinician who is pursuing a particular differential diagnosis may sound to a patient like a non-sequitur, inattention to psychological or emotional content, and at worst, disrespect.

**Alan R, continued:** Example of a missed “window of opportunity“:

Mr. R: “That feeling in my chest reminded me of my father. He had a heart attack when he was 53...same age as me.” Mr. R. looks away distracted.

Doc B: “Did you have any nausea with the chest discomfort?”

Mr. R: “No.”
Doc B: “Any shortness of breath?”

Mr. R: “No.”

When verbal or nonverbal clues about emotions or concerns are dropped, the patient may mention them again, mention them with increasing emphasis and anxiety, or set them aside. (33)

Anchoring statements in what’s just been said helps the clinician explore clues and gather additional information. Responding to the patient’s clues about underlying concerns and emotions tells the patient you have heard her and strengthens your relationship.

**Example of stepping through a “window of opportunity.”**

Mr. R: “That feeling in my chest reminded me of my father. He had a heart attack when he was 53...same age as me.”

Doc B: “Your father had a heart attack when he was 53? What happened?”

Mr. R: “He died. That’s when I took over helping my mother watch out for my brothers and sisters.”

Doc B: “So your father died at your current age. That must be making this even more frightening for you.”

Mr. R: “Yuh. It worries me.”

Doc B: “I can certainly see how it would (pause). Is there anything else you wanted to tell me about that?”

Mr. R: “No, I just want to know what’s happening with me.”

Doc B: “Ok. Would it be ok if I asked you a few more questions?”

Mr. R: “Sure.”

---

**Respond to important clues**

Practice and become adept at responding to clues and feelings in real time.

You may not be able to respond to every clue or expression of emotion.

Smith suggests that statements about feelings (“I’m feeling sad.”), nonverbal expression of emotion (sighing, unhappy facial expression), and more vivid expressions of emotion (crying, laughter) are at the top of a hierarchy of clue importance. (33)

These expressions always warrant further exploration and response. Similarly, if a patient keeps reintroducing a series of clues concerning a specific topic, they should be explored in more detail.

Some experienced clinicians listen closely, encourage the patient to continue, and then respond to a group of clues with a single empathic response. One group calls this “the lasso effect.” (32)

We discuss helpful responses to patients’ emotions in Module 6: "Build the Relationship".

---

**COMMON PITFALLS IN GATHERING INFORMATION**
• Using secondary rather than primary sources of information.
• Narrowing the focus prematurely with closed questions.
• Restricting information gathering to biomedical areas.
• Failing to clarify differences in the meaning of words or statements.
• Controlling conversations rather than facilitating a collaborative dialogue with the patient.
• Failing to reopen inquiry about the patient’s symptoms and concerns throughout the interview.
• Failing to elicit, explore or respond to verbal and nonverbal clues.

**SUMMARY**

You can more effectively and efficiently gather information by using a relationship-centered approach.

Using this approach encourages the patient’s active participation and shares control of interview talk-time and content.

Develop and practice skills to help you explore patients’ symptoms as well as their psychosocial context and patients’ response to their meaning and impact.

You will be more satisfied, and your patients’ will have better outcomes.

**BEHAVIORAL SKILLS CHECKLIST**

• Organize the interview to use allotted time effectively.
• Allow patients to begin telling their stories without interruption.
• Use open-to-closed question strategies, and weave open and closed questions throughout the interview.
• Use verbal & nonverbal continuers and silence to facilitate patient’s active participation.
• For major symptoms, elicit timeline, context, quality, aggravating/relieving factors, location/radiation, quantity/severity, duration/frequency, associated symptoms, and their impact.
• Clarify patients' words or statements.
• Summarize and encourage patients to add or correct.
• Verbalize transitions to new topics and respectfully redirect conversations.
• Anchor questions and statements in what has just been said.
• Avoid negatively phrased or leading questions.
- Share talk time and avoid verbal dominance.
- Integrate biomedical, psychosocial and affective discussion topics.
- Elicit, explore and respond to clues about symptoms, feelings, and concerns.

REFERENCES

Welcome to DocCom Module 9: Understand the patient's perspective

by Beth A. Lown, MD
Rationale

by Beth A. Lown, MD

You greatly improve your patients’ outcomes when you jointly construct the story of the illness, weaving the patient’s elaboration of the biomedical and psychosocial threads together with your own hypotheses.

The primary goals of information gathering are to elicit biomedical and psychosocial information in order to generate clinical hypotheses, and to understand the context and impact of the patient’s illness while continuing to build the patient-doctor relationship.
Questions for Reflection:

1. How would you respond if a clinician asked you to describe yourself? Who are you? What and who is important to you? What life circumstances affect your everyday life, health and well being?

2. How would you explain to a clinician what you value and how you make decisions?

3. Many patients’ perspectives on illness mechanisms – often called an “explanatory model”- differ from the prevailing biomedical model. Have you engaged in conversations with patients about their “explanatory models”?

4. Are you able to inquire non-judgmentally about beliefs and social context?

5. What shifts in your values or attitudes will you need to make in order to better understand patients’ perspectives?

Key Principles:

1. Understanding patients’ explanatory models and responding to them improves medical outcomes.

2. Many factors modify patients’ perspectives, including gender, significant relationships, occupation, education, socioeconomic status, culture, literacy, spirituality/religion, sexual orientation, leisure activities and stressors.

3. Listening for clues about these factors and asking directly about them helps clinicians “see the world through patients’ eyes.”

4. Significant healthcare disparities are mediated in part by clinicians’ conscious and subconscious stereotyping.

5. Self-awareness and reflection upon how ones perspective, assumptions, and biases differ from patients’ improves clinician-patient relationships, communication, and care.

Learning goals:
At the conclusion of this module, you will be able to:

- Endeavor to more consistently appreciate your patients’ perspectives and to “see the world through their eyes.”
- Understand how patients’ social contexts affect their health and illness behaviors.
- Describe and demonstrate skills to elicit patients’ social context, explanatory models, concerns and expectations.
- Explore personal assumptions and potential barriers to understanding patients’ contexts and perspectives.

UNDERSTAND PATIENTS' PERSPECTIVES

Becoming aware of patients’ perspectives and contexts can help clinicians understand why and how they are experiencing illness at this time. Showing interest in their perspectives builds rapport and encourages patients to disclose important information. Combining this behavior with explicit inquiry about each patient’s unique context and situation improves medical outcomes.

Recent trends in American medicine have widened the gap between patients’ experiences of illness and their clinicians’ perspectives. These include the ascendancy of biomedical research with its panoply of new medications and technologies (1), economic pressures on clinicians to see more patients in limited amounts of time, a complex and inequitable healthcare system (3), and increasing diversity of patients in education, culture, language, literacy and socio-economic status (35).

Attention to, and exploration of, patients’ ideas about why they are sick and what should be done transforms the process of care. Patients who express their perspectives and thoughts to their clinicians have improved clinical outcomes and are more satisfied (4-7). Clinicians can develop skills to converse with patients about their perspectives. Often, the resulting dialogue results in more effective management plans and improved patient adherence to those plans. This module elaborates the contextual domains and skills needed to elicit, explore and comprehend patients’ experiences from their points of view, and show how that process improves medical outcomes.

Conflicts between explanatory models

Many patients do not share their clinicians’ biomedical “explanatory model.”

Clinicians live and work in the culture of biomedicine and disease. But patients experience illness and suffering, and clinicians may fail to appreciate the power of this difference. (22). Even when the patient and clinician are aligned on many aspects of culture, for example, on race, gender, religion, and socioeconomic status, the patient may explain and understand the experience of illness in ways profoundly different from the clinician’s understanding of the disease process.

Pneumonia
Ms R., 38 years old and a concert flute player, hospitalized with lower lobe pneumonia and bronchospasm, is on IV antibiotics, inhaled beta-agonist bronchodilators, prednisone, and fluids. Her team was pleased that she was doing well and anticipated discharging her in a day or two.

Ms. R. believed she got pneumonia because extensive travel had weakened her resistance. She wanted to know how to strengthen her body to prevent future episodes. Her career was blossoming and she had more travel scheduled in the near future. She remained upset and anxious and decided to see an acupuncturist to bolster her immune system when she returned home.

Differences in meaning-making cause misunderstandings, poor adherence to recommendations and poor clinical outcomes. Kleinman suggests using nonjudgmental questions to help clinicians understand patients' beliefs about illness. (See questions, below, and (22). Clinicians who employ this type of inquiry will better appreciate their patients' perspectives about illness and treatment.

Kleinman’s "explanatory model" questions will help you elicit patients' beliefs, and initiate dialog that clarifies potential culturally based trouble spots:

- What do you think is causing your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How has it affected you physically? Personally?
- How severe is your sickness?
- How long do you think it will last?
- What are the chief problems your sickness has caused for you?
- What concerns you most about your sickness?

Bring connection and technical expertise

Understanding the patient’s perspective brings clinicians into connection and relationship, supplements the technical work, and transforms clinicians.

Viewing an illness through a patient’s lens transforms patient relationships from a purely technical undertaking to a fully human and healing endeavor. As clinicians explore their patients’ explanatory models in the face of illness and suffering they sometimes become deeply connected, as illustrated in this quotation from clinician and poet William Carlos Williams, M.D.: "I lost myself in the very properties of [my patients'] minds, for the moment at least, I actually became them . . "(38). Such unique and privileged moments are gifts that infuse clinicians’ work with meaning and purpose, and allow suffering patients to feel joined and less alone.

Your gifts of yourself, through full attention, caring and compassion, are neither less important nor more crucial than your technical expertise and competence. All are necessary, and each is insufficient without the others. There are times when showing "expertise" is more highly valued than a "compassionate" verbal statement. For example, research with the parents and clinicians of young leukemia patients shows evidence that technical expertise may be interpreted as compassionate care. "Contrary to current assumptions, parents' sense of emotional connection with doctors did not depend on doctors' emotional behavior, and parents did not feel disempowered by doctors' authority."(39) Superior patient care includes all of these elements because the information obtained and the process of obtaining it will help illuminate why and how the illness is active and which interventions are not only feasible but also compatible with the patient's life goals.
Maintaining a balance between giving to patients and preserving oneself, between expressing compassion and functioning technically in a steady and competent fashion is a central challenge of clinician work (Module 4). Empathic understanding transforms clinicians. Coulehan calls this ability "emotional resilience." (11)

EXPLORING LIFE ISSUES TRANSFORMS CARE

Clinicians often fail to recognize contextual factors and patients’ life issues that strongly impact their health status, often adversely.

Important social context considerations include the patient's roots and cultural identity, gender and sexual orientation, education, language and literacy, occupation, primary relationships and support network, religious or spiritual practices, leisure activities, stressors, mood, financial status as it pertains to healthcare and daily needs to maintain health (12-14). These contextual aspects comprise major elements of personal identity and significantly influence health status. Further, clinicians' understanding of these elements strongly affects patient relationships and clinicians' ability to effectively manage care.

During inpatient rounds, a resident presented a 38-year-old woman who was recovering from a severe bout of her frequently recurring asthma. She had been critically ill and intubated during hospitalization three months previously. This time her recovery was rapid, and she was out of intensive care, ready to start oral medications. When I asked, "Why does this woman keep getting sick?" There was silence until one student ventured, "She is a smoker -- that probably contributes." I suggested that we should ask the patient for her perspective. It was much more than cigarettes; with minimal encouragement she explained that her mother died suddenly two years ago. She felt tremendous guilt that she had not done enough for her mother and resumed her crack addiction, after having been entirely clean for a dozen years. She was now homeless, had no health insurance and couldn't afford her medications. We realized that the team had focused on curing the acute asthma but had not understood her illness. To prevent future hospitalizations the patient needed drug rehabilitation, counseling, and social work intervention.

As many as one third of primary care patients have life issues (excluding psychiatric diagnoses such as depression and anxiety) they identify as adversely affecting health at an office visit, yet clinicians’ recognition of these factors varies widely (8).

Elicit the patient’s social context

Contextual elements of patients' lives significantly influence their health status. Your understanding of these elements affects your patient relationships and your ability to effectively manage care.

Illustrative case discussion

Dr M. saw Ms. H., a 3rd year medical student, for an illness that began six months ago with numbness and tingling in her left leg. The initial symptoms resolved, and in this second
episode, Ms H had numbness in her arms and hands and found it difficult to raise her right arm to brush her hair. Dr M’s exam confirmed weakness as well as sensory deficits. He was concerned about a demyelinating process such as multiple sclerosis. Dr M and Ms H discussed this possibility as well as her thoughts and fears. Dr M wanted to address Ms H’s fatigue and the need for rest with her before she left the office.

Dr. M: “Let’s do the MRI and then we’ll get together to talk about it...How’s it going in your clerkships?”

Ms. H: “OK, I guess. I’m pretty much exhausted all the time but I’ve liked the clerkships I’ve done so far – especially pediatrics.”

Dr. M: “That’s great. That leads me to wonder if the demands of third year are going to be a bit too much for you right now. We may need to think about your taking some time off or slowing down your on-call schedule until we know what’s going on and you’re feeling better.”

Ms. H: “I don’t think I want to do that. It would be hard on the rest of the team and on me not to do what everyone else is doing. I’m o.k. for now.”

Dr. M: “I can see how committed you are. I wonder if making some adjustments might nevertheless be helpful?”

Discussion:

Ms. H. hoped that Dr. M. would reassure her that her symptoms were not serious, but she had already researched the various diseases that could cause them. How could she possibly reduce her schedule? Everyone else would have to pick up her load, plus she couldn’t delay her graduation. Her family expected so much of her, both in terms of professional and financial success, and she had incurred a substantial debt. Ms. H. was the first person, let alone the first woman, in her family to go to college. Her parents were immigrants with few resources, had medical problems and spoke little English, and a younger sister was in trouble with drugs. She had to do well enough to get a good internship and then return home to help both her family and her community.

If Dr. M. has Ms. H.’s well being in mind, but does not understand the complexity of her life context, how would his recommendation of a respite from her duties (to Ms. H. or to her Dean) be received and acted upon by Ms. H.?

The remainder of this module highlights selected components of the patient’s context and the major impact of differences in how patients’ understand and explain illness. Other modules address in more detail the issues of cultural identity (Module 15), gender and sexual orientation (Module 18) and spirituality (Module 19). Many of these elements are contained in the "Social History." (Module 5) We present evidence about the utility of this information and discuss the process of eliciting and understanding the patient’s perspective.

**Socioeconomic inequality**

To be effective in explorations with patients, sustain a belief in the importance of inquiry about context, listen to answers non-judgmentally, and prepare to examine your assumptions about patients. We all carry preconceptions, often unconsciously.

**Discussion:**
Mr. G, 44, came to urgent care because of lightheadedness. He recently began work for a construction company and was painting a building on a sunny day when he felt lightheaded. He managed to get off the scaffolding, rested, got up to get some water, but noticed his vision “tunneling in” as if he were about to pass out. Friends brought him water but he remained lightheaded, so he came in. Mr. G has had hypertension that was difficult to control on an angiotensin converting enzyme inhibitor, beta blocker, and diuretic. At the clinic, his sitting blood pressure was 100/60 and pulse 65, standing 80/60 and pulse 65. His physical exam was otherwise unremarkable and EKG showed only sinus bradycardia.

Doctor N thought that dehydration superimposed on Mr. G’s antihypertensive regimen had caused the symptoms. He decided to ask about Mr. G’s perspectives and life issues.

Doctor N: "So what do you think caused this problem?"

Mr. G: "I hate to admit it, doc, but this is the first time I have had insurance for years, and this is the first week I have taken all my medicines. Before, I filled one or another prescription whenever I could afford it. I suppose I should have told someone."

Discussion:

Socioeconomic status is a strong predictor of health status, and lower socioeconomic classes have significantly higher mortality and poorer health. The report, "Income, Poverty and Health Insurance Coverage in the United States: 2003" shows increasing disparities in income and health. In 2010, 15.1 percent of all persons in the US lived in poverty, the highest poverty rate since 1993. In previous studies, people in the poorest households were 4-5 times more likely to die in the next 10 years than those in the richest (15). Marginalized social groups have little control over health-related societal resources (16). Lack of health insurance is directly associated with increased mortality, adverse health outcomes, and increased likelihood of avoidable hospitalizations and emergency care (17). In 2010 an estimated 16.3% of people (about 49.9 million) were without health insurance.(2)

Communication about insurance and money

Uninsured patients are understandably reluctant to talk about lack of money and insurance. Patients may be unable to follow their clinician's advice due to financial and insurance problems. Patients seldom admit, usually because of embarrassment, that they didn’t fill a prescription, or tried to stretch out the prescription by taking the medicine every other day. Communication research data show that patients are more willing to disclose this information if their clinician inquires in a non-judgmental fashion.

Talk about financial and insurance issues

Normalize the issues by saying:

"Some patients have financial problems that can affect their health"

Elicit information by asking questions such as:

- "Have finances been a problem for you?"
- "Have money problems prevented you from getting medical care? Medicines?"
Clinicians may differ from patients in many culturally determined ways -- in addition to the “culture of bio-medicine” issues. Some are obvious, others subtle.

Culture is “the lens through which we give our world meaning.” (18) It can be broadly defined as “an integrated pattern of learned beliefs and behaviors that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views of roles and relationships, values, practices, and customs.” (19) Culture is a key aspect of patients’ social context. We are all immersed in multiple cultures by virtue of characteristics such as age, gender, sexual orientation, race/ethnicity, professional training, socioeconomic status, and religion, to name a few. In fact, each patient-clinician encounter is a cross-cultural encounter between multiple unique life-world differences, including the culture of biomedicine. Clinicians’ cultural competency significantly affects their ability to understand patients’ perspectives.

Core cultural issues include how patients regard individual autonomy vs. group authority when making decisions about healthcare; mistrust of clinicians and the healthcare system based on prior experiences of discrimination; non-verbal styles of communication such as eye contact and personal space; perceptions of the role of the clinician and efficacy of biomedicine; the role of cultural traditions and customs; and gender or sexual-orientation based roles and expectations within cultures. In a given conversation it is often difficult to discern whether a specific cultural difference, whether subtle or obvious, influences communication, diagnosis and treatment.

The challenge is to understand which cultural processes or issues are salient to a particular patient at any given time. Clinicians should familiarize themselves with communication patterns, health habits, special religious or ethnic beliefs and prevalent diseases in the various cultures and communities in which they practice. This is always an imperfect process, however, and application of any generalized assumption may results in poor care. (examples: “Older people dislike revealing themselves to younger doctors;” or “men care less about emotions than women,”)

---

**Cultural Competence**

Culturally competent clinicians hold the assumption that neither their own cultural perspective, nor their patients’ cultural views are “superior;” nor is the culture of medicine the only way to understand illness.

Cultural competency or “cross-cultural efficacy,” (19) is the ability to hold the assumption that while different, neither yours nor the other person’s culture is superior. Milton Bennett describes a continuum in the development of intercultural sensitivity. People typically progress from ethnocentric stages of denial, defense or minimization of difference to the ethno-relative stages of acceptance, adaptation and integration of difference.(21) The shift into ethno-relativism as defined by Bennett is mediated by empathy (Module 5, 6, 13), or the ability to temporarily shift one’s frame of reference to see the world “as if” through the eyes of another person. In this module, we highlight some core cultural inquiry skills; Module 16 goes into more detail about understanding and negotiating cultural differences in medical settings.

Core cultural issues include the following:

- **Autonomy**: how patients regard individual autonomy vs. group authority when making decisions about healthcare;
- **Trust**: mistrust of clinicians and the healthcare system based on prior experiences of discrimination;
- **Habits**: non-verbal styles of communication such as eye contact and personal space;
- **Roles**: perceptions of the role of the clinician and efficacy of biomedicine;
- **Traditions**: the role of cultural traditions and customs;
Gender expectations: gender or sexual-orientation based roles and expectations within cultures.

Inquire about core cultural issues

- Would you like me to include family or anyone else as we talk?
- Would you prefer to see a man or woman clinician?
- What kinds of experiences have you had with doctors or in getting the care you need?

Biomedical culture

Be prepared to communicate with patients about differences between their perspective on an illness process and a biomedical “explanatory model.”

Clinicians think in terms of pathology and the pathophysiology of disease. However, patients' experience illness, pain and suffering, not "pathology." The magnitude of this difference in perspective varies dramatically from one situation to another. For example, a person with lung cancer may share the clinician's biomedical perspective, while the same patient with a headache or depression may not. Furthermore, many problems do not fit any single, simple model; alcoholism and domestic violence are examples. Exploration of the differences in perspective results in better communication and improvements in care.

Some time ago Kleinman suggested nonjudgmental questions to help clinicians understand patients' beliefs about illness. The questions are still entirely relevant to clinical care, and clinicians who employ this type of inquiry will better appreciate their patients' perspectives about illness and treatment. (22)

Kleinman’s “explanatory model” questions will help you elicit patients’ beliefs, and initiate dialog that clarifies potential culturally based trouble spots:

- What do you think is causing your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How has it affected you physically? Personally?
- How severe is your sickness? How long do you think it will last?
- What are the chief problems your sickness has caused for you?
- What concerns you most about your sickness?

Self-treatment

Many of your patients will try home remedies, complementary or alternative therapies.

Most patients take some action to relieve symptoms. Many patients use healing practices specific to a culture with which they identify. Sixty seven percent of U.S. respondents used at least one complementary and alternative therapy in their lifetime. (23)

The extensive use of folk healing practices and complementary therapies (24) suggests that clinicians will often receive useful data in response to a question such as, "Do you see other therapists or healers for advice about your health?"
Elicit information about self-treatment behaviors:

- What treatments have you tried so far?
- Have you tried any over-the-counter, alternative, or home remedies?
- Have you seen any providers besides me about this?
- What kinds of treatments do you think would be most helpful?
- What are the most important results you hope to receive from this treatment?

Language

Language barriers contribute to suboptimal health outcomes.

Language barriers play a part in suboptimal healthcare and outcomes. In the U.S. population over 5 years old, 17.9% speak a language other than English at home. Over 21 million people speak English "less than very well." (25) Patients who speak English as a second language may appear to be fluent since they speak well, but may not understand all that you say, and be embarrassed to admit this. When explaining medical care issues to these patients, it is often helpful to ask them to explain to you their understanding of what you have communicated, "to make sure that I have explained it to you clearly enough."

Elicit information about language:

- What language do you speak at home?

Literacy

Low literacy is a barrier to adequate health care, and it predicts worse health outcomes, despite higher healthcare utilization.

Health literacy is defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.(26)" The National Adult Literacy Survey showed that nearly 50% of adults have difficulty understanding and acting on health information. Health-related materials are seldom written at the level of patients’ reading and comprehension skills. In one large survey, 42% of patients could not understand directions for taking medicine on an empty stomach and 26% did not understand information about their next scheduled appointment.

Patients with low literacy have worse health outcomes and greater risk of hospital admission (28). A 2011 review confirms the inverse relationship of outcomes to literacy(39). Among patients with heart failure in an integrated managed care organization, low health literacy was significantly associated with higher all-cause mortality. (40) Low literacy correlates with mortality, lower adherence to anticoagulation therapy, poor diabetic control, and higher health care utilization and costs.

Generally, people are ashamed or embarrassed about reading and comprehension problems, and are more likely to respond to invitations offered gently and in a non-judgmental fashion. Recommendations for uncovering this problem in a nonjudgmental fashion are shown below.

Normalize the issue by saying:

- Some of my patients have trouble reading. Is this a problem for you?
Elicit information about literacy:

- How happy are you with the way you read?
- Does anyone at home help you read or follow medical instructions?
- What would help you learn more about this problem?
- What would help you take this medicine properly?

Stereotypes

Clinicians, like other members of society, may apply conscious and unconscious stereotypes to patients that result in poor communication and poor care.

Studies indicate that clinically meaningful disparities in healthcare persist even after adjustment for socioeconomic factors. Research substantiates the presence of socially conditioned and usually unconscious prejudicial attitudes among providers (20), whose perceptions are affected by patient ethnicity, race, socioeconomic status and other factors. People match individuals to various social categories, which spares the use of cognitive resources, but can lead to the use of stereotypes through which attitudes and beliefs about a group of people are unconsciously applied to an individual thought to be a member of the group. Some evidence suggests that time pressure, the need to make rapid judgments, task complexity and cognitive load increase the likelihood of applying stereotypes. Many factors contribute to the application of stereotypes (30), including cultural and individual differences, language barriers or differences in communication style in the description of symptoms. Another factor, particularly in the presence of clinical uncertainty, may be clinician use of categorization strategies to simplify the cognitive processing of complex information (31).

Mr. S., a 32 year old man with sickle cell trait, was hospitalized for the third time in the past 6 months, this time for a hot swollen knee. The orthopedics consultant tapped the synovial fluid, found no evidence of infection, and suggested that the patient had an anserine bursitis.

On teaching rounds, the intern presented Mr. S’s history and indicated suspicion about Mr. S’s complaints of severe pain. The attending clinician demonstrated a moderate knee joint effusion, limited range of motion and no tenderness over the anserine bursa. After the team left the bedside, the attending asked how the physical findings affected their differential diagnosis. A resident stated that regardless of diagnosis, the patient was “a drug-seeker.” Therefore his complaint of pain was unreliable and should not affect plans for treatment or disposition.

Injustice, inequity and disparities

Assumptions and stereotypes superimposed on a national history of racial discrimination contributes to healthcare disparities and distrust of the healthcare system and clinicians by many patients. Clinicians have a special responsibility to address this societal problem.

Stereotyping leads to bias and disparities in care (29). The assumptions clinicians and patients make confound appropriate health care. Over 700 clinicians who viewed videotapes of actors portraying patients with the same story of chest pain referred women and blacks significantly less often for cardiac catheterization than men and whites. (37) When clinicians believe that patients won’t adhere to treatments, they are less likely to make recommendations. Furthermore, a legacy of racial discrimination and mistrust of health professionals, especially within the African American
population, discourage some patients from seeking care or following up on it (20).

Every clinician has a social responsibility to recognize and minimize healthcare disparities, and to promote social justice within the health care system (34). Diversity training and studies demonstrate that “perspective-taking,” especially when focused on imagining a particular group member’s feelings, can arouse feelings of empathic concern and reduce prejudice and stereotyping (35). Every clinician has a personal and professional responsibility to know their patients as individual persons rather than as a conglomerate of stereotypes, social categories, or unexamined biases, and to strive to understand their patients’ perspectives on healthcare matters.

AnnotatedVideo (not shown in print-out text)

CONCLUSION

Understanding the context of patients’ situations and their perspective on illness and medical care improves medical outcomes. Avoiding stereotyping, unexamined assumptions and biases improves communication and minimizes both mistrust and disparities in care.

- **Listen for and elicit** stories and information that shed light on patients’ unique contexts, and reveal their perspectives about illness - their “explanatory models.”
- **Examine and reflect** on stereotypes, assumptions and prejudice.
- **Inquire** non-judgmentally about patients’....
  - perspectives about illness - explanatory models
  - culture
  - social context
  - language and literacy
  - “explanatory model” of this illness
  - self-treatments and visits to alternative healers
  - financial and health insurance situation

BEHAVIOR SKILLS CHECKLIST

- Demonstrate willingness to view situations from patients’ perspectives
- Ask about life events, circumstances, and other people that affect health.
- Elicit patients' beliefs, concerns, and expectations about illness and treatment (their explanatory models)
- Inquire non-judgmentally (a little or a lot, depending on situation) about a patient’s
  - culture
  - social context
  - language and literacy
  - “explanatory model” of this illness
  - self-treatments and non-medical helpers
  - financial and health insurance situation

LITERATURE REFERENCES

Welcome to DocCom Module 10:
Share information

by Beth A. Lown, MD
Facilitator Guide of this module for DocCom Residency Doctoring Curriculum

Credits:

Author: Beth A Lown, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient: Theresa Whitlock
Clinician on camera: Beth A Lown, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
- 3.0 - 12/14/2011 MP4 and HTML5 enhanced
- 2.0 - 7/27/2009 Update to DocCom Version 4.0
- 1.0 - 6/27/2005

VIDEO (not shown in print-out text)

Rationale
by Beth A. Lown, MD

VIDEO (not shown in print-out text)

The Patient's View

VIDEO (not shown in print-out text)
The Doctor's View

Questions for Reflection:

1. Remember a time when you effectively shared diagnostic or treatment information with your patients (if you have not yet had clinical encounters, remember when clinicians effectively shared information with you or your family.)

2. What skills or facilitators made the conversation effective? What actions or behaviors limited a full understanding of the information?

3. How might you structure your clinical conversations to maximize your patients’ understanding.

Key Principles:

1. The goal of sharing information is to enable patients to understand and cope with illness (and prevention) in collaboration with their clinicians.

2. Skillful and compassionate sharing of information improves patient adherence and clinical outcomes.

3. The fundamental relationship-centered information-sharing strategy is to use repeating cycles of “Ask-Tell-Ask.”

Learning goals:

At the conclusion of this module, you will be able to:

- Understand the challenges that you will face when sharing information with patients
- Describe and demonstrate a systematic, relationship-centered approach to sharing information
- What skills do you need to practice to improve your relationship-centered sharing of information, and when will you do this?

INTRODUCTION AND OVERVIEW

The introduction section of this module is outlined as follows:

- **How much information should clinicians share with patients?**
  Relationship-centered information sharing improves outcomes. However, patients’ desires for information are often not met in clinical practice.

- **What are the goals of sharing information?**
To further empower patients, we teach many patients self-management skills that are based on two assumptions.

- **Will patients retain information?**
  People are most motivated to learn when they identify a need or a problem.

- **Patients are often afraid to ask questions.**
  Embarrassment or worry impedes patients from asking for additional information.

- **Knowledge, science, uncertainty and information-giving**
  Say “I don’t know” when you don’t, and modulate your information giving when the information is emotionally charged.

---

**How much information should clinicians share with patients?**

The word Doctor derives from Latin, “docere” which means “to teach.”

Relationship-centered information sharing improves outcomes. However, patients’ desires for information are often not met in clinical practice.

The burgeoning number of websites on health topics attests that patients want information about their bodies and their health. In particular, patients want their clinicians to provide health-related information.(1) Studies indicate that patients’ psychological distress improves, symptoms resolve, and clinical outcomes (eg, blood pressure control) improve when clinicians supply clear information with emotional support.(2-5) When clinicians supplement their information with printed materials, patients’ mood, anxiety and function improve and pain decreases.(6-8) Effective patient education improves adherence to plans,(9) and patient education programs that include self-management strategies result in reduced healthcare utilization, less lost work time and improvement in symptoms.(10)

Clinicians overestimate the time they spend educating patients and under-estimate how much information their patients want.(11-13) A large nationwide survey noted that 10% of discharged patients reported not receiving information they wanted, and 25% felt they didn’t receive enough information about how much pain and discomfort to expect during procedures or post-operatively. One third of patients said their doctors and nurses didn’t answer their questions understandably, and up to 45% of patients said they weren’t told what danger signs to watch for after discharge. (14)

---

**What are the goals of sharing information?**

To further empower patients, we teach many patients self-management skills that are based on two assumptions. The first is that if patients and clinicians collaborate as partners, they can define goals and strategies better than either could do alone.(15) The second is the reality that patients with chronic diseases already make daily management decisions.

The essential goal of sharing information is to empower patients to optimize their health. Traditional patient education teaches patients how their bodies function in health and in specific disease states, and how to maintain health and prevent illness. When patients have symptoms or are ill, we share information about diagnosis and diagnostic testing plans, including risks, benefits, alternatives, and results. We help patients understand about prognosis, what to expect; and the components of treatment plans and the rationale for them. Clinicians and other healthcare
professionals teach technical and home monitoring skills that allow patients to manage chronic illnesses effectively.

Self-management education emphasizes self-directed goal setting and behavioral regulation.\(^{(16)}\) It teaches patients self-monitoring techniques (such as keeping symptom diaries, blood sugar, blood pressure, or peak flow measurements) and encourages patients to keep records of whether prescribed interventions affect their symptoms (such as taking nitroglycerin before anticipated exertion). Patients learn how to adjust their medications according to a written action plan tailored to their needs and disease severity.\(^{(17)}\) They can apply problem-solving skills to medical issues as well as social and emotional problems that arise when coping with chronic illness.\(^{(18,19)}\) Clinicians who help patients link with community resources enhance the effectiveness of this approach to patient education.\(^{(20)}\)

For patients with chronic diseases, traditional patient education compares poorly to self-management education. For example, programs that focus on asthma knowledge do not decrease hospitalization rates, doctors’ visits for asthma attacks, time lost from school or work, medication usage, or improve lung function.\(^{(21)}\) In contrast, establishing collaborative relationships results in fewer symptoms, cost benefits from fewer hospitalizations and emergency visits, improved lung function and better quality of life.\(^{(22)}\) Arthritis self-management education produces similar outcomes and cost reductions.\(^{(23)}\)

### Will patients retain information?

People are most motivated to learn when they identify a need or a problem. Use exploration of current knowledge, repetition, checking feelings and checking understanding to maximize retention.

Adult learning theory transformed our approach from the notion of passive information transfer to the facilitation of active, collaborative, self-directed learning.\(^{(24)}\) Most adults prefer to be self-directed, and are motivated to learn when life experience introduces a need, a problem or an interest. For information you wish to convey, exploring patients’ existing knowledge about a particular issue and building upon their knowledge, past experiences and current needs helps you facilitate their learning.\(^{(25)}\) Other specific teaching strategies are associated with good patient recall. These include simplification, repetition, specificity, reinforcement, exploring patients’ ideas and feelings about the information, and checking the patient’s understanding.\(^{(26)}\) (see module 9)

### Patients are often afraid to ask questions

Embarrassment or worry impedes patients from asking for additional information. Anticipate this or use gentle prompts to help reluctant patients disclose concerns and ask questions.

Patients want information, but may not ask key questions because they are afraid of the answer; such as in, “Am I going to die?” “How long do I have to live?” “What if I don’t wake up from anesthesia?” or because of embarrassment or a sense of shame; such as, “Will this affect my sex life?” “Did I do anything to make this happen?” Patients may be embarrassed about not knowing how their bodies work, not doing what is good for them– and do not want to appear ignorant or negligent. Often you may anticipate that patients will fear asking certain questions, and can address the issues directly, “Many patients worry about resuming sex after they have had a heart attack. Is that a concern of yours?” Patients frequently wait to ask the embarrassing questions until the end of the encounter. They will only ask them if they trust that you will be non-judgmental and perceive you have the time. Stating up front that you have the time, and want to answer all their concerns, and continuing to ask, “Are there other concerns?” will often bring out
the deepest or more embarrassing concerns. You could also ask gently, “Is there anything you’ve been afraid to ask me?”

**Knowledge, science, uncertainty and information-giving**

Say “I don’t know” when you don’t, and modulate your information giving when the information is emotionally charged.

Medicine is a profession based upon knowledge and science, as well as uncertainty. Patients know that new science emerges daily, that today’s truth may be proven wrong by tomorrow’s evidence and that no clinician can keep up with every new development. They appreciate that acknowledging uncertainty is a sign of clinical maturity rather than academic weakness; as long as you demonstrate that you care enough about them personally to seek relevant information on their behalf. It’s important to say, “I don’t know” when you don’t, to seek the information you need, and to bring your findings back to the patient.

When your information giving is emotionally charged you should also clarify with your office staff or hospital team who is the most appropriate person to share information with a given patient. In advance, determine how much content will be shared, especially when discussing test results, prognosis, or communicating bad news. Giving premature advice, tentative plans or reassurance to patients and families before obtaining and clarifying all of the relevant information is counter-productive and can be harmful.

**LEARN THE FUNDAMENTAL STRATEGY FOR SHARING INFORMATION: ASK-TELL-ASK**

When clinicians share information they predominantly TELL information, often in too much detail, and in terms that sometimes alarm patients. Information sharing is most effective when clinicians remain sensitive to the emotional impact of their words. By using a strategy of ask-tell-ask, you will greatly enhance patients’ understanding and promote adherence to plans.

Adult learning theory and self-management education strategies inform us how to communicate most effectively and teach information to patients. The fundamental points are that we need to stay in dialogue (not monologue), begin with an assessment of the patient’s needs, tell small chunks of information tailored to those needs, and check on the patient’s understanding, emotional reactions and concerns. This is summarized by the three step format, “Ask-Tell-Ask.” Each step includes several discrete issues.

A simple skill, namely, alternating between telling small amounts of information, then checking for understanding and asking your patients about its effect on them, will help you effectively modulate the amount and type of information that you share and efficiently communicate what your patients need most.

**What to ask and tell**
ASK to assess patient emotional state and the patient’s desire for information. TELL small amounts of information in simple language, and ASK about the patient’s understanding, emotional reactions and concerns.

Many conversations between clinicians and patients sound like, “Tell-Tell-Tell,” and some people call this monologue “doctor babble,” because clinicians seem to be talking to themselves, rather than having a dialog or conversation with patients. Remember to use the Ask-Tell-Ask format so that you remain in dialogue with your patients. Here is a list of the ASK’s and TELL’s that covers important areas for sharing.

Click on the hyperlinks to go directly to the section indicated.

**ASK to assess patient needs**
- Make sure the setting is conducive.
- Assess the patient’s physical and emotional state.
- Assess the patient’s informational needs
- Assess the patient’s knowledge and understanding.
- Assess the patient’s attitudes and motivation
- Assess the patient’s level of literacy.

**TELL information about diagnosis, treatment or other aspects of the situation**
- Keep it brief
- Use a systematic approach
- Build on the patient’s prior experience
- Personalize information
- Use simple language, avoid jargon
- Choose words that do not unnecessarily alarm
- Use visual aids
- Offer supplemental materials

**ASK about the patient’s understanding, emotional reactions and concerns**
- Assess the patient’s understanding
- Elicit and respond to the patient’s emotions
- Elicit additional concerns and/or questions

**ASK to assess patient needs**

The ASK section consist of the following items:

- **Assure privacy, check with the patient that setting is conducive**
  Patients cannot properly receive and react to information if the setting is disruptive or public.

- **ASK: Assess the patient’s physical and emotional state**
  If patients express emotional distress, acknowledge, explore and respond to their feelings at the moment of their expression.

- **ASK: Assess the patient’s informational needs**
  Elicit the patient’s questions and concerns up front, asking “anything else?” until the patient acknowledges that all concerns have been expressed.

- **ASK: Assess the patient’s knowledge and understanding**
Building on baseline knowledge-targeting your information—is efficient and respectful, and more likely to transfer the new information than if you start with whatever you assume is most important.

- **ASK: Assess the patient’s attitudes and motivation**
  Patients will not be interested in hearing your health information if they are not motivated, or if they have negative attitudes about the outcomes of their efforts, so ask about this directly.

- **ASK: Determine the patient’s level of literacy**
  Low literacy is common and seriously limits understanding. Ask simple questions that check literacy, and learn resources that you can make available to patients.

---

**ASK: Assure privacy, check with the patient that setting is conducive**

Patients cannot properly receive and react to information if the setting is disruptive or public. Clinicians should not share sensitive information in public places.

Consider the setting before sharing information. Do all you can to ensure that the setting is conducive to a comfortable and honest information exchange. Sharing information in a hallway, when the patient is on a stretcher in a busy ER, or in a waiting room breaches the patient’s right to privacy. If a hospitalized patient is in a semi-private room, you may want to draw the curtains, or, if the information you need to share is sensitive, you may want to move to a more private setting. Turning off radios or TV’s can be helpful. You may need to ask people to step outside, or include appropriate family members or friends. You should sit down if telling all but the most elemental information.

---

**ASK: Assess the patient’s physical and emotional state**

If patients express emotional distress, acknowledge, explore and respond to their feelings at the moment of their expression.

If patients are upset or anxious, address their emotions and concerns before trying to share information. Sharing information when the patient is sleepy, sedated, in pain or emotionally distraught is not respectful and the information won’t be remembered. With hospitalized patients, ask if the patient is comfortable and ready to talk. If they are not comfortable, take steps to assure their comfort.

---

Check out the video example about "assessment of the patient's physical and emotional state" on the left.
Here are some more examples:

**Patient A:**
“What do you mean I need to have an operation?”

**Doctor A:**
“I know this is upsetting news. Let me tell you why you need the surgery, then I’d like you to tell me your worries about it, ok?

**Patient B:**
“How can I possibly check my blood sugars, inject insulin, eat and get to school on time? Why can’t I just be like everyone else?”

**Doctor B:**
“I know – sometimes it just doesn’t seem fair. How can I help you with this?”

**Patient C:**
“Can’t you just do an x-ray? Why do I need to have a colonoscopy? My mother in law had that and said it was a terrible experience”

**Doctor C:**
“I’m glad you told me that. I’d like to speak to your concerns. What did she say was terrible about it?”

**ASK: Assess the patient’s informational needs**

Elicit the patient’s questions and concerns up front, asking “anything else?” until the patient acknowledges that all concerns have been expressed. It may be helpful to write down the questions and concerns, and you may need to negotiate priorities and timing for providing extensive information.

Find out what information the patient wants, and in what format. Some patients want detailed information about their conditions, tests and proposed treatments, recommendations for reading, websites, self-help groups, and referrals to other consultants. Others want an overview and general understanding. Patients may want other family members to be present for support or to help them remember key points. Be prepared to respect the patient’s wishes.

Reaching agreement with the patient about what information to review may require negotiation if your understanding of the issues, priorities, or goals are different. Also, some patients may need more time, so you might agree to discuss the key points, and plan to address others later, or refer them to other staff or health educators.

**Doctor A:**
“So, tell me all your questions and concerns about your medical problem, and I’ll address them one by one.”

**Doctor B:**
“I have some information I’d like to go over with you—would you prefer to hear an overview, or lots of the details?”

**Doctor C:**
“Is there a particular issue you’d like information about right now?”
Doctor D:  
"Should we talk about this now or would you rather wait until your daughter comes in?"

Doctor E:  
"I know you’re upset right now. Should we talk about next steps now, or would you like to wait until I come by tomorrow?"

Case Mr. P and Dr. L.

Sometimes the patient’s informational needs are greater than the patient imagines.

Mr. P. is 76, admitted with worsening angina pectoris in the setting of non-operable coronary artery disease. He has diabetes, hypertension, hyperlipidemia and renal insufficiency, as well as other chronic medical problems. During the admission his anti-anginal regimen was adjusted and additional medications added for diabetes. A nutritionist talked with Mr. P about an appropriate diet.

Prior to his discharge, Dr. L sat down with Mr. P. to review his medications and diet and exercise instructions.

He looked distracted, so she asked,  
“You look preoccupied. What’s the matter?”

He replied,  
“Well Doctor, the real problem is my wife. She has multiple sclerosis and I have to lift her onto the commode, wash her up, get her into the chair and then back into bed. I’ll be lifting her, feel my angina coming on and it scares me, but what can I do? I just try to tough it out. I have my son at home. You know, he’s schizophrenic and he’s been away for the past month anyway. I’ve got my sister staying home with my wife now that I’m in here, but she’ll have to go back home to her husband. So – I’ll do my best about taking my medicines and eating right and all, but sometimes it’s just about all I can do to take care of her...and don’t tell me to put her in a nursing home! I don’t want to hear about it.”

In Mr. P’s situation, information about his medications and disease processes is not sufficient. His clinician needs to think with him about where to get household assistance, how to avoid situations that precipitate his angina, and when to call for help or emergency services. He also needs ongoing emotional and medical support from his clinician.

ASK: Assess the patient’s knowledge and understanding

Building on baseline knowledge-targeting your information-is efficient and respectful, and more likely to transfer the new information than if you start with whatever you assume is most important.

Learning theory suggests that adults learn best by building on previous knowledge. Find out what previous knowledge or relevant experience patients have about a symptom, or about a test or treatment. Include this data as you shape the information you share; you might tell different information about diabetes to a PhD biochemist than to a construction worker. Assess patients’ understanding of the nature of their problems in the context of their lives, their motivation to
address these problems, and the barriers they must overcome.

Check out the video example about "assessing the patient’s knowledge and understanding" on the left.

Patients may understand the essentials of blood sugar control, for example, but their poor control is related to financial and social issues. Others, well motivated, do not understand how blood sugar relates to ingestion of certain foods, or how much insulin to take for a certain blood sugar level. Sometimes when you ask about patients’ understanding, they reveal feelings. For example, asking a depressed patient his understanding of depression might elicit, “I don’t know, I guess I’m just a failure…” After responding to the emotional expression, you can then educate about common emotional reactions in depressive disorders, and discuss some of the neurochemical basis of depression. Learn to ask directly: “Tell me your understanding about the causes and complications of diabetes” Assessing patients’ understanding of a topic enables you to target your education, and build on the patient’s baseline knowledge.

**ASK: Assess the patient’s attitudes and motivation**

Patients will not be interested in hearing your health information if they are not motivated, or if they have negative attitudes about the outcomes of their efforts, so ask about this directly.

You can start by asking general questions about attitudes and motivation: “So – tell me how you feel about all of this?” “This is a complicated regimen. How do you think you will manage?”

If patients are not motivated, ask why, and help the patient work through the issues. A useful framework for understanding and responding to patients’ levels of motivation is the Health Belief Model. (see Appendix) Do not give up when patients express lack of motivation or unwillingness to follow your advice. Good evidence about what you might say and do instead of using exhortation or admonishments exists, and much of this is outlined in Module 16 For this module, we focus on simpler encounters.

**ASK: Determine the patient’s level of literacy**

Low literacy is common and seriously limits understanding. Ask simple questions that check literacy, and learn resources that you can make available to patients.

Over 40 million people in this country have low literacy skills and may not be able to read written information. Further, literacy is strongly linked to comprehension of important medical issues. For example, a study in both English and Spanish diabetic patients showed that only half with low literacy knew the symptoms of hypoglycemia (compared to 94% with higher literacy), and fewer patients with hypertension and low literacy knew that blood pressure could be lowered with diet and exercise. Patient education materials, discharge instructions and standard consent forms are written at higher reading levels than many patients can understand.
Do not assume patients’ literacy level based upon their level of education or their self-reported reading abilities, because neither predicts actual literacy.(30,31)

Check out the video example about "assessment of the patient’s level of literacy" on the left.

You can inquire about literacy by asking:

Doctor C:
"How happy are you with the way you read?"(32)

Doctor D:
"Some of my patients have trouble with reading. Are you able to read this?"

Patients who cannot read are embarrassed, so be sure to respond non-judgmentally and with empathy. Familiarize yourself with resources available to help patients in your clinical environment. Verbal review of instructions, checking patients’ understanding, clarifying and answering questions, drawing pictures and diagrams each helps patients remember and recall information.(33) Pictures of clocks indicating the time medicines should be taken, with colored pictures of the pills to be taken (or actual taped-down samples of the pills) next to the correct time increase understanding and adherence.

**TELL (share) information about diagnosis, treatment or other aspects of the situation**

Strategies for TELLING information include:

- **TELL: Keep each bit of information brief**
  It is difficult to understand and retain large amounts of information, especially when one is physically ill, upset or fearful.

- **TELL: Use a systematic approach**
  Use a template that you can practice and repeat consistently. For example, name the problem, the next step, what to expect, and what the patient can do.

- **TELL: support the patient's prior successes**
  Explicitly mention and appreciate patients’ previous efforts and accomplishments in coping with previous problems or illness.

- **TELL: personalize the information**
  Personalize your information by referring to the patient’s personal and family history.

- **TELL: Use simple language, avoid jargon**
  Use simple language and be mindful of how you frame key points.
TELL: Choose words that do not unnecessarily alarm
Words and phrases we take for granted may be misinterpreted or alarm patients and families.

TELL: Use Visual Aids/ Share Supplemental Resources
Find reliable resources and educational aids to meet the needs of your patients.

TELL: Keep each bit of information brief

It is difficult to understand and retain large amounts of information, especially when one is physically ill, upset or fearful.

Share information that’s based on what the patient wants and what you feel you need to convey. Don't try to convey more than a few pieces of information at a time.

Check out the video example about "keeping each bit of information brief" on the left.

TELL: Use a systematic approach

Use a template that you can practice and repeat consistently. For example, name the problem, the next step, what to expect, and what the patient can do.

Use a consistent strategy so you can be organized and more effective at facilitating patients’ learning. Ley and colleagues suggest the following basic template for sharing information. Modify this template depending on what the patient wants to know and your own personal preferences. Keep your statements brief; and pause between statements so that patients can keep up with the flow.

- What you think the problem or diagnosis is.
- What test or treatment you think should be offered and why.
- What to expect.
- What patients can do to help themselves.

For example, "I think you have a bladder infection. (pause) We’ll send your urine sample to the lab to see what bacteria is causing it because this is the second infection you’ve had in a short period of time, and I want to be sure that I’ve given you the proper antibiotic, ok? (pause) You should start to feel better within 2 days, but if you’re not, or you develop a fever please be sure to call me. (pause) Meanwhile, drink plenty of fluids and I’ll call you when I get the culture report back.” (pause)

When you are about to provide information about several issues, let the patient know your
organization at the beginning. For example, “We’ll need to talk about your diet, exercise, and insulin. I think it would be better to focus on your cholesterol at our next visit. Does that sound ok to you?”

**TELL: support the patient’s prior successes**

Explicitly mention and appreciate patients’ previous efforts and accomplishments in coping with previous problems or illness.

Reminding patients of previous successful efforts to cope with and manage illness supports their strengths and reinforces self-confidence and motivation. (35) Most patients can tell you of at least one successful coping strategy or accomplishment if you ask about them explicitly. Patients can draw upon their memories of prior successes to build future efforts. This is especially helpful in helping people change entrenched behaviors. (36) You can then respond directly to patients’ comments to acknowledge and support the attitudes, values, or strategies they found to be personally helpful in the past.

![Check out the video example about "supporting the patient’s prior successes" on the left.](image)

“You’ve been able to quit smoking in the past and that’s an excellent predictor that you’ll be successful again. Let’s figure out what worked for you before.” (pause, or ASK)

“You’ve really figured out a great system for recording your sugars and matching them with your symptoms. It’s very helpful.” (pause, or ASK)

**TELL: personalize the information**

Personalize your information by referring to the patient’s personal and family history.

“We don’t know if your dad had high blood pressure, but since he had a stroke in his 50’s, it’s likely that he did. It makes it even more important that we work together in keeping your blood pressure normal.” (pause, or ASK)

“I know your wife and children mean a lot to you, and they need you. You’ve told me that you want to see your kids grow up. If we work together to keep your blood sugar normal, and you quit smoking, you have an excellent chance of living a healthy long life. What do you think?”

**TELL: Use simple language, avoid jargon**
Use simple language, avoid jargon.

Use simple, everyday language. In learning medicine, we are accustomed to complex sentences and long paragraphs.

Check out the video example about "using simple language and avoiding jargon" on the left.

As clinicians, we tend to think in a multilayered fashion, exploring multiple diagnoses, diagnostic strategies and treatment options in our minds. Expressing all of these details can be confusing, or evoke alarm. Use simple sentences and short paragraphs. Words and phrases we take for granted, such as “differential diagnosis” or “edema,” are not necessarily familiar to patients. Take a moment to organize your thoughts and think about how to present information simply, clearly, and without using jargon.

**TELL: Choose words that do not unnecessarily alarm**

Words and phrases we take for granted may be misinterpreted or alarm patients and families.

The words we use have a profound impact on sick and vulnerable patients and their families. Stories abound about the misuse of “words that maim,” such as referring to left coronary occlusions as “the widow maker,” or telling a patient, “You’re living on borrowed time.”(38) Patients’ association of the word “syndrome” with Down’s syndrome during genetics counseling discussions caused significant anxiety.(37) Other commonly used words, such as, “cervical incompetence” or “congestive heart failure” may leave patients feeling somehow defective or at fault for their physical conditions.

Check out the video example about "choosing words that do not unnecessarily alarm" on the left.

It is important to provide explanations and information when we discuss diagnosis or prognosis, using commonly understood words like “cancer” or “heart attack” so that patients and families understand and can plan.

**TELL: Use Visual Aids/ Share Supplemental Resources**
Find reliable resources and educational aids to meet the needs of your patients.

Use visual aids or draw pictures to illustrate your points (even if you have no “artistic” talent!). Engage your office staff or hospital team to help inform and motivate patients to utilize other resources.

Check out the video example about "sharing supplemental resources" on the left.

Supplement your conversations with other educational information, such as written flyers, audiotapes, audiovisual material, and computer-assisted instruction, including the internet. Refer patients to other providers for additional teaching and information. Help your patients locate and enroll in appropriate programs. Know what self-help groups are locally available to provide more information and support.

Now that you have reviewed the components of TELL, you are ready to finish the sequence, as you attend to checking how the patients are receiving your sharing of information.

**ASK: Continue to assess needs, comprehension and concerns**

After each bit of telling, stop and check in with patients. When you think you are about finished, make a final check. (below) This step closes the feedback loop with patients, and you will understand what patients hear, whether they are “taking home” the messages you intended and how they are feeling about the situation. (You are preparing the ground for Reaching Agreement (Module 11,) and Providing Closure (Module 12)).

The second ASK section consist of the following items:

- **ASK: Check for patients' comprehension**
  ASK about your patients’ understanding. This ASK improves patient recall, satisfaction, and adherence.

- **ASK: Check for emotional responses and respond appropriately**
  Letting patients know that you have heard their concerns and worries is compassionate, improves outcomes and takes little time.

- **ASK: About barriers**
  Patients may face external obstacles as well as internal emotional responses that inhibit them from overcoming these obstacles.

**ASK: Check for patients’ comprehension**
ASK about your patients’ understanding. This ASK improves patient recall, satisfaction, and adherence.

Up to 40% of patients have problems recalling what was said during medical encounters.\(^{(39-41)}\) Checking for patients’ understanding aids patient recall and satisfaction with the interview.\(^{(42,44)}\)

Check out the video example about "checking for patients’ comprehension" on the left.

Checking for understanding during discussions leading to decisions was rare in a study of audi-taped medical office visits, occurring in a mere 2% of them.\(^{(43)}\) A study of videotaped preoperative cardiac surgery discussions showed that checking on patients’ understanding by clinicians, nurses or health educators occurred in 0.9-1.3% of discussions.\(^{(44)}\) Audiotapes of encounters with low literacy patients with diabetes showed that clinicians checked for recall and comprehension in less than 16% of visits after presenting a new concept, and, glycemic control improved when clinicians’ did assess understanding.\(^{(45)}\)

Some clinicians ask their patients to “teach back” what they have learned. This may be especially effective for patients with low literacy who cannot rely on written reminders.\(^{(34)}\) It is important to normalize the process and put the burden on your own shoulders:

"I always check in with my patients to make sure that I’ve explained things clearly. Can you tell me how you’re going to take this new medicine?" If the patient’s explanation is incorrect, you should then say, "I'm sorry, I guess I didn't explain things all that well: let me try again." Then go over the information again and ask the patient to teach it back to you again.

In addition to asking patients to repeat back the most important information and instructions, it is important to encourage patients to voice their questions and concerns. It is best to do this before the end of the encounter when you have the time to address their questions, and to ask in an open ended manner. Instead of asking, "do you have any questions?" to which patients often reply, "no," instead ask,

"What questions or concerns do you have?"

**ASK: Check for emotional responses and respond appropriately**

Letting patients know that you have heard their concerns and worries is compassionate, improves outcomes and takes little time.

Patients who are sick often feel vulnerable and afraid, and experience a sense of loss of control over their lives. Eliciting and responding to patients’ feelings help them feel joined, supported and cared for. Many clinicians try to express caring in their conversations with a thoughtful focus on
the biomedical issues, but avoid talking about any associated feelings. This “focus on facts” fails to address patients’ needs for emotional support. Patients appreciate being cared for as persons, not just as diseases.

Check out the video example about "checking for emotional responses and respond appropriately" on the left.

This very simple act improves outcomes and need not prolong visit times. When patients express emotion, either verbally or nonverbally, respond to them with skills we presented in Module 6: name or inquire about the patient’s emotion; respond with legitimation or expressions of partnership, reassurance, support or praise.

Check for emotional reactions:

“How are you feeling about all of this?”

“Are you feeling nervous about your… (test/surgery/chemotherapy)?”

ASK: About barriers

Patients may face many barriers to ensuring health or coping with illness including lack of social support or financial resources, feelings of being overwhelmed, anxious or depressed and others. If you ask patients directly about the obstacles they perceive, you can help them being to think about strategies to overcome them.

Check out the video example about "asking about barriers" on the left.

"Are there any barriers that you can see that might get in the way of your doing this?"

SUMMARY
Clinicians can share information and build collaborative relationships by using specific communication strategies. Use **ASK-TELL-ASK** to stay in dialogue and to assess and respond to patients’ information needs and emotions. (Use emotion-responding skills from Module 6.) Celebrate and support patients’ successes. These efforts will help meet your patients’ needs and improve their clinical outcomes.

**BEHAVIOR SKILLS CHECKLIST**

**ASK to assess patient needs:**

1. Make sure the setting is conducive.
2. Assess the patient’s physical and emotional state.
3. Assess the patient’s informational needs
4. Assess the patient’s knowledge and understanding.
5. Assess the patient’s attitudes and motivation
6. Assess the patient’s level of literacy.

**TELL information**

7. Keep any one presentation or statement brief
8. Use a systematic approach
9. Build on the patient’s prior experience
10. Personalize information
11. Use simple language, avoid jargon
12. Choose words that do not unnecessarily alarm
13. Use visual aids and offer supplemental materials

**ASK about the patient’s understanding, emotional reactions and concerns.**

14. Assess and check the patient’s understanding
15. Elicit concerns and/or questions
16. Elicit and respond to the patient’s feelings
17. Assess Barriers

**APPENDIX - Health Belief Model**

Certain theories of patient health promoting behaviors are useful to know and can guide your counseling.

For example, you could elicit and respond to patients’ thoughts about the components of the Health Belief Model, as it applies in their situations. This model was designed to help explain why people undertake health promoting behaviors or comply with recommended treatments for illnesses. It asserts that patients’ behaviors are related to certain perceptions and attitudes about health behaviors. This table summarizes the core concepts of the model:

<table>
<thead>
<tr>
<th>Definition</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perceived Susceptibility</strong></td>
<td>One's opinion of chances of getting a condition</td>
</tr>
<tr>
<td></td>
<td>Define population(s) at risk, risk levels. Personalize risk based on a person's features or behavior. Heighten perceived susceptibility if too low.</td>
</tr>
<tr>
<td><strong>Perceived Severity</strong></td>
<td>One's opinion of how serious a condition and its sequelae are specified. Correct misperceptions, challenge patient denial.</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Perceived Benefits</strong></td>
<td>One's opinion of the efficacy of the advised action to reduce risk or seriousness of impact. Define action to take: how, where, when; clarify the positive effects to be expected from these actions.</td>
</tr>
<tr>
<td><strong>Perceived Barriers</strong></td>
<td>One's opinion of the tangible and psychological costs of the advised action. Identify and reduce barriers through reassurance, incentives, assistance.</td>
</tr>
<tr>
<td><strong>Cues to Action</strong></td>
<td>Events, either bodily (e.g., physical symptoms of a health condition) or environmental (e.g., media publicity) that motivate people to take action. Offer strategies to activate 'readiness.' Provide how-to information, promote awareness, reminders.</td>
</tr>
<tr>
<td><strong>Self-Efficacy</strong></td>
<td>Confidence in one's ability to take action. Provide training, guidance in performing action. Give positive feedback, support successes.</td>
</tr>
</tbody>
</table>


### LITERATURE REFERENCES

13. McIntosh A, Shaw CFM. Barriers to patient information provision in primary care: patients’ and general practitioners’ experiences and expectations of information for low back pain.
39. Stewart M. Patient Recall and Comprehension After the Medical Visit. In: Lipkin M, Jr.,...
Welcome to DocCom Module 11:
Reaching agreement

by Beth A. Lown, MD
Credits:

Author: Beth A Lown, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient: Theresa Whitlock
Clinician on camera: Beth A Lown, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.0 - 12/15/2011 Enhanced with MP4 videos and HTML5 code
2.0 - 7/28/2009 Update to DocCom Version 4.0
1.0 - 6/27/2005

VIDEO (not shown in print-out text)

Rationale
by Beth A. Lown, MD

VIDEO (not shown in print-out text)

The Patient's View

VIDEO (not shown in print-out text)

The Doctor's View
Questions for Reflection:

1. We all have experience with reaching agreements with friends and family every day. What are your strengths in helping others reach agreements? What gets in the way?

2. How effectively do you listen to the wishes, intentions, and preferences of others? How often do you assume you know what these are?

3. What skills would you use to help you reach agreement with patients with whom you disagree on their wishes or preferences for diagnostic or treatment plans?

4. What kinds of patients or patient behaviors might get in the way of your negotiating agreements about diagnostic or treatment plans?

5. How might preconceived notions or judgments about patients get in the way of your reaching agreements with patients?

Key Principles:

1. An effective process of reaching agreement and making decisions about diagnostic or treatment plans is based on a collaborative model of the patient-clinician relationship.

2. The majority of patients want information about their health, illnesses and decision options, but their preferences about participation in decision making are quite variable.

3. Substantial empirical evidence shows that patients’ active participation in their health care and planning enhances health outcomes as well as patient satisfaction.

4. In a collaborative model, topics to be discussed in order to reach agreement with patients and families include the following:
   - the nature of the problem
   - the roles and responsibilities of both the patient and clinician
   - the goals of treatment

5. The process of reaching agreement includes explicit communication skills, with the conversation elaborated or collapsed, depending on the complexity of the decision to be made.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe conceptual models of decision making and reaching agreement.
- Describe evidence regarding patient participation in their decisions and care.
- Describe their own attitudes, preferences and approaches to partnering with patients in decision making.
Describe and demonstrate skills for reaching agreement about decisions and plans.

INTRODUCTION TO "REACHING AGREEMENT"

Reaching agreement is a complex process that includes identifying the nature of the problem, defining preferred roles and involvement in decision making, agreeing on goals, and gathering and sharing biomedical and psychosocial information. Participants in this process must address feelings, concerns, and preferences, while building consensus and collaborating to create shared decisions. Checking for mutual understanding helps to clarify and confirm agreement.

After you have elicited the patient’s history, completed the physical exam and formulated your thoughts about the patient’s problems and how to manage them, the next step is discussing your ideas with patients, listening to their ideas, and reaching agreement about the plans. Without this critical step, patients in the hospital cannot know and have no say in what’s happening or being done to them and why. Ambulatory patients face the same dilemma, but in this setting, the implementation of the plans rests in their hands. The way you go about reaching agreement with patients will reflect your beliefs about the roles of patient and clinician, and your approach to the patient-clinician relationship.

MODELS OF DECISION-MAKING BETWEEN PATIENTS AND CLINICIANS

Both patients and providers can be trained to enhance participatory styles of communication, resulting in improved health outcomes.

Patients’ involvement in decisions about their care is an increasingly important priority for healthcare providers, policy makers, medical organizations, and the public sector(1-3). During recent decades, medical ethicists have emphasized the importance of patient autonomy and respect for the patient’s right to self-determination(4,5). Research contributions suggesting that patient participation enhances health outcomes have combined with these social forces to induce significant shifts in the patient-clinician relationship.

Several paradigms help us conceptualize the nature of the decision making aspects of the clinician-patient relationship. In the “paternalistic” model, the beneficent clinician makes decisions on behalf of patients without including them. At the other end of the spectrum, in the “informed consumer” model, patients gather information from multiple sources, including from their clinicians in order to choose among available treatment options. In this model, the patient makes decisions independently and autonomously and the clinician’s role is primarily as one source of information. In the “professional as agent” paradigm, clinicians make choices on behalf of patients based on what they know (or assume) about patients’ preferences. In yet another model, “collaborative,” clinicians and patients share information and preferences and search for consensus about diagnostic and treatment decisions and plans (6). The latter model requires clinicians’ willingness to collaborate, and patients’ willingness to participate and assume shared responsibility for decisions.

Patient preferences and clinician communication behaviors
Patients want information but vary in their interest in actively collaborating in decisions. Clinicians are not good judges of their patients’ preferences for decision-making.

A 1980’s Harris poll of patients and clinicians undertaken for a President’s Commission for the study of ethical problems in medicine and biomedical research indicated that 72% percent of patients thought the patient and doctor should discuss alternatives about a clinical decision and decide together what to do. Only 7% wanted the doctor to present alternatives and let the patient decide, and another 7% wanted the doctor to decide for them. Twelve percent wanted the doctor to present a recommendation for the patient to accept or reject. A later cross-national study of Australian, UK and US preferences also indicated that participants preferred mutual or joint decision-making. Clinicians’ communication practices have not kept pace with these patient preferences.

A study of over one thousand audio taped office visits of US primary care clinicians and surgeons showed that only 9% of decisions met criteria for fully informed decision-making. Another group studied “routine” clinical decisions and found that the most frequently discussed element (83% of discussions) was the nature of the problem, whereas discussions of risks and benefits and assessment of patient understanding were infrequent (9% and 2% of discussions respectively). Forty per cent of over 6,000 hospitalized patients in a recent nationwide survey said they did not have enough say in their in-hospital care.

Most patients want information about their illnesses and decision options, but their preferences for participation in decision making are variable. Even those patients who wish to actively collaborate in decision making may not wish to do so in every instance, depending in part on the patient’s age, culture, acuity, and severity of illness. Unfortunately, clinicians are often poor judges of their patients’ preferences about participation in decision making.

Patient participation in decisions and health outcomes

Psychological and physical health, efficiency of care, and frequency of malpractice claims improve when patients are more involved in decisions about their care. Focused interventions, either with patients or their clinicians, enhance patient involvement in decision-making.

Giving patients information and collaborating actively with them about their care enhances psychological and physical health outcomes. Stewart comprehensively summarized the evidence that four communication elements directly enhanced emotional and physical health, symptom resolution, and functional status. The four key elements included:

1. provision of clear information
2. questions from the patient
3. willingness to discuss and share decisions
4. agreement between patient and clinician about the problem and plans

Patients’ perceptions of reaching agreement about clinical decisions have been correlated with improved efficiency of care, reflected by fewer diagnostic tests and referrals. An intensive communication intervention for critically ill patients in which patients, families and the critical care team together discussed goals, expectations and care plans resulted in reduced ICU stays for patients who died, and in earlier access to palliative care for dying patients. Several studies have correlated malpractice claims with clinician communication that failed to involve the patient in decisions about care. The communication problems cited included inadequate discussion of diagnosis or treatment plans, patients feeling ignored, and devaluing or failing to understand patient and family perspectives.

Communication skills training for patients or clinicians can enhance collaborative participation and clinical outcomes. Interventions with patients have included detailed review of their problems and
individual coaching (22,23), provision of written information and verbal encouragement to participate in decisions to the extent desired (24,25), and provision of a communications training workbook prior to scheduled office visits (26-28). The results of these interventions are enhanced participation in primary care interviews (27), assumption of a more active role in decision making (24,25), improved health outcomes (blood pressure and glucose control), and improved functional status (22,23). Studies of communication skills training interventions for health care providers (primarily primary care clinicians) show increased focus on patients’ preferences and shared control of clinical decisions with associated significant increases in patient satisfaction (29).

**DOMAINS FOR REACHING AGREEMENT OR UNDERSTANDING WITH PATIENTS AND FAMILIES**

A collaborative approach to decision making requires the integration of the knowledge, values, needs and preferences of both patients and clinicians.

The clinical encounter is a “meeting between experts (30),” to which patients bring expertise about their life context, concerns, beliefs and values, and clinicians bring biomedical and technical expertise. This collaborative, relationship-centered care approach requires mutual respect and willingness to share control and responsibility for decisions and plans. It is not an “either/or” approach, but a “both/and” approach (31).

The tasks of building, understanding and reaching agreement occur in the following key domains, and we describe communication skills within each of these domains in the following sections:

- What is the nature of the problem?
- What are the preferred roles of the participants in decision making?
- What are the goals of treatment?
- What is to be done?
- How will the plans be implemented?

**What is the nature of the problem?**

It can be difficult to reach agreement about what should be done if you and the patient have different ideas about the nature of a problem. This aspect of finding common ground requires understanding the patient’s explanatory model, including their perspective regarding the cause of the problem, its severity, and its expected course.

**Illustrative case: Mr. H’s stomachache**

Mr. H. is a 32 year old construction worker whom you’ve seen once for an initial visit. He described occasional episodes of cramps and diarrhea, and a previous clinician had prescribed an antispasmodic agent for presumed irritable bowel syndrome. Mr. H. had no symptoms at the time of your visit and you suggested that he come in to see you if the symptoms reoccurred.

Mr. H: “Hi Doc. Good to see you. Listen, I think my ‘irritable bowel’ problem is kicking up again. You know, that doctor that was here before you gave me a medicine for stomach spasms and I wondered if I could get some more. I’ve had a lot of diarrhea and cramps lately.”
Dr. D: “Well, let’s hear a bit more. Is anything different from previous episodes?”

Mr. H: “Actually I’ve been seeing some blood mixed in with the stool and in the toilet water. I thought maybe I aggravated some hemorrhoids with all the diarrhea.”

Dr. D: “Hm. How long has that been happening?”

Mr. H: “Off and on for about 6-8 weeks I’d say.”

Dr. D: “Ok, and are you having any pain in your belly?”

Mr. H: “It comes and goes, but it feels kind of uncomfortable down low on the left a lot.”

Dr. D: “I’ll want you to show me where when I examine you. Now, my assistant recorded your weight as 157. That’s down 8 pounds since I last saw you a few months ago.”

Mr. H: “Yuh, I think what with the cramps and diarrhea I haven’t felt much like eating.”

In this vignette, Mr. H believes his symptoms are due to irritable bowel syndrome. He minimizes the significance of the blood in the stool, pain, and weight loss, perhaps due to anxiety, denial or inadequate knowledge about their significance.

Dr. D: “So it sounds like you’re thinking that these symptoms are due to irritable bowel syndrome and hemorrhoids?”

Mr. H: “That’s what I was thinking I guess…why, what do you think?”

Dr. D: “I’m concerned that there might be more going on. Irritable bowel does not usually cause bloody diarrhea, localized pain and weight loss.”

Mr. H: “What do you think is going on?”

Dr. D: “I’m not sure. The symptoms you describe may be caused by patches of inflamed bowel, chronic infection, sometimes even a tumor. We’ll need more information to make good decisions about treatment. I think we should do some tests to see if you have an area of bleeding in the bowel. What are you thinking about all of this?”

Mr. H: “Like what kinds of tests?”

As the conversation progresses, Dr. D ask about the patient’s understanding, needs and feelings about the problem (see DocCom module 9) then begins to share information and answer questions (see module 10).

If Dr. D advises a procedure without trying to reach common ground on the nature and implications of the patient’s symptoms, Mr. H may feel confused, angry, or compelled into an action plan he doesn’t understand and isn’t ready to accept. Dr. D’s task now is to share additional information about the significance of Mr. H’s symptoms, and how the tests will help establish a diagnosis. The patient and clinician may not fully agree, but if they respect each other’s explanations, it may be possible to integrate, or to try parallel approaches to the diagnostic or treatment plans.

What are the preferred roles of the participants in decision making?
Patients’ preferences may change in different situations, so it’s important to ask explicitly about their preferences for participating in decision-making. Sharing responsibility for decisions does not mean abandoning the patient. When clinicians express their opinions, give advice, and offer guidance, patients feel supported and clinicians fulfill their professional responsibilities. (32)

Some patients want their clinicians to make decisions for them, while others want to act independently. Patients who want the clinician to make decisions for them however, will usually engage in conversations about their goals for health and quality of life in illness. Ultimate choices belong to the fully informed patients. (33) However, this does not mean that clinicians should abandon patients as they make decisions. Clinicians are responsible for continuing to actively participate in their patients’ care and follow-up while patients are responsible for implementing agreed upon plans once they leave the hospital or office setting. At times full agreement cannot be reached. If the disagreement is serious, the patient and clinician may have to decide whether or not to continue their relationship. Fortunately, this is an infrequent occurrence.

**Illustrative case continued: Mr. H’s stomachache**

Dr. D: "We can do simple blood tests and send a stool specimen to the lab, and I’d like you to see a gastroenterologist to look inside the bowel directly."

Mr. H: "Do you really think that’s necessary? I thought this was a flare up of these old problems."

Dr. D: "Well, that may be, but I wouldn’t want to assume your symptoms are due to irritable bowel and hemorrhoids until we exclude other problems. What questions do you have at this point?"

Mr. H: "I understand that we need to figure out what’s going on. I just don’t like the idea of it. I’d like to speak with my brother about it. He’s a doctor."

Dr. D: "I’d be happy to speak with your brother if you’d like. How are you feeling right now?"

Mr. H: "Anxious."

Dr. D: "What concerns you the most?"

Mr. H: "Could this be a cancer, Doc?"

Dr. D: "I can understand your worry about that. I am concerned, too, but we don’t know enough at this point, and we will discuss your lab results as they emerge. How can I be most helpful to you right now?"

Mr. H: "I just need to think about this."

Dr. D: "Ok. How shall we make a decision about what to do next?"

Mr. H: "How about if I give you a call in a couple of days."

Dr. D: "That sounds fine."

Mr. H. indicates he is willing to listen to Dr. D’s advice, but also wants to participate in the decision making by weighing the necessity for a referral, and by speaking with trusted advisors. He also needs time to absorb the information about the potential seriousness of his symptoms before he can agree on a diagnostic plan. Dr. D for his part, must realize that he has just shared difficult news, and respect the patient’s need for time to think and to seek additional advice, without feeling that his authority is being challenged.
Other strategies that Dr. D could try in clarifying the role Mr. H would like to play in making decisions about tests and management options include:

- How shall we make this decision?
- *It sounds like you’d like to think about this, do some reading, and talk about it more later.*

Check out the video example about "decision making" on the left.

Sometimes clinicians and patients desire the input of others, such as consultants or the patient’s significant others. Strategies that Dr. D could try include:

- *Is there anyone you’d like me to speak with?*
- *I’d like to get some advice from one of my consultants who specializes in this field.*

Check out the video example about "consultation" on the left.

What are the goals of treatment?

Patients’ goals may change as they live through an illness. This observation, and the fact that clinicians are inadequate judges of patients’ preferences, highlights the necessity to revisit the complex decisions about diagnosis and treatment as time goes by.

After sharing information to understand each other’s definition of the problem, the next step is establishing mutual understanding of the patient’s and clinician’s goals for a proposed diagnostic or treatment plan. Deber makes the distinction between patient’s desires to participate in decisions by weighing values and alternatives, versus “problem-solving” or making technical decisions about which specific tests or treatments are medically likely to clarify or resolve a problem. She postulates that most patients want to participate in weighing decisions, but not in deciding the technical aspects of care. (33) Quill and Brody also advise clinicians to focus first on overall goals, rather than technical or specific aspects of treatment. Clarifying the goals
Check out the video example about "clarifying the goals of treatment" on the left.

Illustrative case about Mr. P’s cancer and Resident W.

Mr. P. was an elderly successful businessman recently diagnosed with metastatic lung cancer. Mr. P. asked his family and Dr. L. to sustain him with whatever treatments his clinicians thought indicated until his quality of life or clarity of mind were compromised, at which time he preferred to be kept comfortable. He remained functional for a few weeks until his wife noticed that he was having word-finding difficulty. Dr. L. then noted brain metastases and initiated radiation, anticonvulsant, and steroid therapy. Mr. P. agreed, but by the 3rd hospital day, he was exhausted and asked for a respite from radiation treatments. The house staff noted his limited oral intake and abnormal electrolytes, renal and liver function.

Resident W: “Hi Mr. P. Your labs look like you’re dehydrated and your nutrition is poor. I’m going to start a long intravenous line so we can give you some fluids and total parenteral nutrition.”

Mr. P. said quietly, “Why? It’s too late for that. I don’t want any of this. I want to go home.”

Strategies to help establish the patients goals of health and illness management include:

- What are your hopes and goals for your health?
- What’s most important to you at this stage of your illness? (also see module 9)

What is to be done?

The first tenet of a shared decision is that it must meet the goals agreed upon by both patient and clinician.

The processes involved in reaching such an agreement are the following:

- both patient and clinician participate
- both patient and clinician share information including medical knowledge, values, beliefs, concerns, thoughts and goals
- both express their preferences
- both agree to the plans (35)

The processes of gathering and sharing information, building consensus, and reaching agreement are complex, and are sometimes daunting because of the nature of clinical uncertainty (36). Clinical uncertainties make communication of risk to patients extremely complex and difficult. The way professionals frame information about risks and benefits greatly affects how patients receive and act upon this information. For example, positive framing spoken in terms of chance of survival is more persuasive in encouraging patients to take risky options than negative framing
spoken in terms of **chance of death** (37).

The skills to accomplish this are always relevant, and the conversation may be elaborated or truncated according to the complexity of the decision. In the face of urgent decisions, clinicians are likely to give too much information too quickly, and to attempt to persuade patients instead of helping them reach the best decision. Having a skill set and strategies available is essential to reaching agreement with patients. The chart below provides a guideline of communication skills for reaching agreement, with examples of clinician statements and questions to implement the skills.

<table>
<thead>
<tr>
<th>Skills guideline</th>
<th>Skills examples</th>
</tr>
</thead>
</table>
| Present options including the proposed plans/procedure, it’s risks, benefits, and alternatives. (See M17) | “One option would be to do this procedure/take this medication. It’s risks are... The benefits are... Alternatives would include...”  
“The absolute risk of a woman/man having this disease by age ... is 1 in (x)... This intervention will increase/decrease this risk to 1 in (y).”  
“The risk of serious side effects from this intervention is...”  
“Let’s think about what this means for you personally.” |
| Be explicit about the limits of your own knowledge and the scientific evidence available. | “Statistics give us an accurate picture of what happens within a group of people, but cannot tell us what will happen for any particular individual –you, for example- in that group.”  
“Data about the long-term effects of this medication/procedure are... (extensive; or scanty).”  
“I’m not certain about the data/best thing to do in your situation. I will check with experts and textbooks and then we can talk more about this decision.” |
| Elicit the patient’s preferences about the available options. | “What are your thoughts about these options?”  
“How are you feeling about this?” |
| Present your own opinion and advice. | “In my experience...”  
“My advice would be...” |
| Acknowledge non-judgmentally areas of agreement and disagreement. | “It sounds like we both agree that our goal would be to ..., but so far it seems we disagree about the best next steps?” |
| Validate the patient’s right to make choices. | “My advice is that you (quit smoking, undergo this operation), but the choice is clearly yours.” |
| Work with the patient to integrate the patient’s feelings and preferences into a mutually agreeable decision. | “We both agree that our goal is for you to..., and you’ve said that you’re reluctant to... Let’s think together about how to move ahead and get the best result for you.” |
| Avoid overwhelming patients with information, or berate, cajole, or harass patients when they do not quickly agree with your recommendation. | “I’d like to provide just the right kind of information to help you decide. Right now, I see you are not ready to make a decision yet.” |

Clinicians see the problems, pain and suffering that may arise if urgent measures are delayed by
Because we wish to spare patients as much suffering as possible, we may try to explain too much, give too much information and fail to appreciate patients’ decision dilemmas. We may marshal as much evidence for our recommendation as possible, trying to persuade the patient to do the “right thing” especially if we foresee dire consequences. The communication dynamic becomes distorted because patients cannot absorb excessive information, and too much persuasion tends to result in resistance. These communication dilemmas can be repaired by listening and responding to patients’ views instead of repeating, reconfiguring or bolstering our own. Our professional obligation is to integrate our own expertise and preferences with our patients’ so that they can live their lives, and make decisions as they see fit.

How will the plans be implemented?

Patients live in their own worlds where decisions are activated only if they choose and are able to implement the plans.

The realities of daily living and contextual factors alter patients’ readiness to contemplate the changes necessary for self-care, and their ability to carry them out. It’s important to reiterate the agreed upon plans, to check for mutual understanding, and probe whether the patient is able to implement them. Sometimes, the patient simply is not able to follow through with the agreed upon plans.

Mrs. N’s Dilemma

Mrs. N. incurred an ankle injury when she was running across a playground to reach her toddler. Her clinician found a severe sprain, and prescribed ice, leg elevation, non-steroidal anti-inflammatory medications and crutches. She returned a week later with continued pain and swelling. Her clinician asked if she had followed instructions, and she replied that she had not. When asked, she explained that she waitresses during the day while her son stays with a neighbor. Her family lives in Canada. After work it is impossible to elevate her leg or use crutches as she either used the stroller or carried her son when outside, and inside he is “all over the place!” She felt embarrassed to share this and feared that her clinician would interpret her reluctance as a rejection of his advice.

Skills guideline

Check for mutual understanding

Check for readiness, barriers and need for additional resources

Skills examples

“Just so I can be sure I’ve been clear, let’s summarize the plans.”

“How ready do you feel to pursue this plan?”

“What problems do you anticipate in carrying out these plans?”

“What resources might be helpful?”

In situations like Mrs. N’s, the clinician’s responsibility is to continue to be supportive, provide information, identify barriers and problem-solve with the patient. The clinician may identify other professionals to serve as resources, such as patient educators and social workers. Similarly, the patient may identify family or friends as resources and supports.
Mr. W.’s Hepatitis C and Dr A.

Dr. A, the primary care clinician for 43 year old Mr. W., made the diagnosis of Hepatitis C. She frequently urged him to stop drinking alcohol, explaining that alcohol hastens progression to cirrhosis. Mr. W. did not agree that his six beers nightly was a problem, after all he had his job and no legal or other difficulties, and his wife drank with him. Dr. A. inquired periodically about his thoughts and feelings about drinking, continuing to share her concern that alcohol was harmful for his health.

One day, 5 years after he entered her practice, he told her he had quit drinking.

"Why now?" asked Dr. A.

"Because I was ready, my wife quit, and you told me to," he replied.

Clinicians should look at inability to follow through with agreed plans as a signal to reappraise the feasibility of the decisions made, rather than labeling the patient as “non-compliant.” When this occurs, the patient and clinician should identify barriers to implementation, problem-solve together, and identify available resources and other people to help.

Additional communication skills are applicable in situations where patients chronically fail to implement plans (see module 16), or cannot agree with a diagnosis (especially stigmatized diagnoses, like alcoholism (see module 29), depression (see module 27) or HIV infection.

**SUMMARY**

Reaching agreement is a complex process that begins with identifying the nature of the problem, defining preferred roles and involvement in decision making, and agreeing on goals for the next steps.

It also includes gathering and sharing information about biomedical knowledge, feelings, concerns, and preferences, toward building consensus and collaborating to create shared decisions. The clinician and patient work toward mutual understanding. In the collaborative model, inability of patients to follow agreed upon plans signals the need for reassessment of prior decisions, rather than labels of noncompliance. Clinicians can enhance their patients' clinical outcomes and satisfaction by using this collaborative model.

**COMMON PITFALLS**

- Making assumptions about patients’ preferences for participation in decisions.
- Failure to discuss and define the nature of the problem.
- Failure to discuss and agree on the goals of treatment.
- Recommending and prescribing plans and instructions without working through the processes needed to reach agreement.
- Overlooking the need to re-evaluate goals and decisions over the course of a patient’s illness.
- Interpreting a patient’s failure to implement agreed upon plans as “non-compliance” rather than checking understanding, identifying barriers, and problem-solving together if the patient is willing.

### Behavior Skills Checklist

- Ask about the patient’s understanding, needs and feelings about the problem.
- Share information and answer questions.
- Clarify the role the patient would like to play in making decisions about diagnostic tests and management options.
- Involve consultants and the patient’s significant others as desired.
- Ask patients about their goals for health and illness management.
- Present options, including risks, benefits, and alternatives.
- Be explicit about the limits of your own knowledge and the scientific evidence available.
- Elicit the patient’s preferences about the available options.
- Present your own opinion and advice.
- Acknowledge non-judgmentally areas of agreement and disagreement.
- Validate the patient’s right to make choices.
- Work with the patient to integrate their feelings and preferences into a mutually agreeable decision.
- Check for mutual understanding.
- Check for readiness, barriers and need for additional resources.

### Bibliography


Welcome to DocCom Module 12:
Provide closure

by Beth A. Lown, MD
Credits:

Author: Beth A Lown, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient (Ms. Allen): Liz Walz
Clinician on camera: Beth A Lown, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.
Version History:
3.0 - 12/15/2011 - Enhanced with HTML5 code and MP4 videos
2.0 - 7/28/2009 Update to DocCom Version 4.0
1.0 - 6/27/2005

VIDEO (not shown in print-out text)

Rationale

by Beth A. Lown, MD

VIDEO (not shown in print-out text)

The Patient's View

Loading...
The Doctor's View

Questions for Reflection:

1. How do you feel when you're trying to close an interview and patients are trying to expand the discussion?

2. What barriers might there be for you either in the patient's behavior or in yourself that might limit your ability to close an interview smoothly?

3. Are there certain types of patients with whom you might want to prolong your interviews?

Key Principles:

1. Your behaviors at visit closure can strongly influence your patients’ outcomes.

2. Before you attempt to close, use these strategies to avoid unduly prolonged closure:
   - orient your patients to the flow of the encounter
   - elicit their perspectives throughout the encounter
   - reach agreement before you try to close

3. Your major tasks at closure are the following:
   - check understanding of the plans
   - arrange follow-up
   - express support until next time.

Learning goals:

At the conclusion of this module, you will be able to:

- describe clinician behaviors that facilitate effective visit closure.
- describe clinician and patient behaviors that interrupt or prolong closure.
- describe your approach to saying goodbye to patients in various clinical settings.
- describe and demonstrate specific communication skills for providing closure.

INTRODUCTION

Closing an interview is a complex endeavor, and your success depends both on your skillful approach to preceding interview segments and the skills you employ in the closing moments.

The closure of any patient encounter includes specific behaviors and interactions that influence the patient’s implementation of plans, the patient’s health, and the patient-clinician relationship. Yet, studies indicate that the closing moments of an encounter are quite brief. In one study, visits
averaged 16.8 minutes and in 72% of them, closure lasted less than 1 minute. Effective beginnings facilitate successful completions, so your skillful execution of earlier interview segments greatly facilitates effective closure.

WHY DOES CLOSURE DIFFER FROM SHARING AND PLANNING, AND WHEN DOES CLOSURE BEGIN?

As the end of the visit approaches, conversation turns from the present to the future. The challenge is achieving clear agreement on what happens next. Use the skills of summarizing, clarifying, expressing supporting, and saying goodbye.

Closure is the time for checking and reviewing plans, expressing support, and saying goodbye. In actual interviews, a demarcation line between reaching agreement on plans and closure of the interview is seldom clear. At the close of visits the conversation shifts from a present to a future orientation, and the clinician and patient confirm that they each understand and agree about what will happen next. The tasks of closure include orienting the patient to the close of the visit, summarizing, reviewing and checking the diagnostic or treatment plans for understanding, clarifying and arranging follow-up, and acknowledging, reassuring or supporting the patient before saying goodbye.

Problem: Interrupted or prolonged closures

Welcome explorations of new topics early in interviews, but toward the end, keep invitations to explore new material to a minimum in order to efficiently bring the interview to a close.

Certain clinician behaviors prolong closure; such as eliciting new concerns during closure rather than earlier in the interview, or failing to reach common ground on an issue with a patient. Prolonged closures are less likely when you take time at the beginning to orient patients to the flow of the visit, to elicit concerns, to give adequate information about treatment plans, to explore patients’ beliefs, and to respond to patients’ feelings.

If you or your patients introduce new or unresolved issues late in the interview, this action prolongs or interrupts effective closure. Often patients fail to disclose the issues that are really bothering them until they perceive that their clinician is starting to close the interview. Usually, these “hidden agendas” appear because they are difficult psychosocial concerns or physical symptoms that cause the patient anxiety, or are known to be associated with potentially serious implications, such as chest pain. Sometimes new issues arise late because they emerge as the conversation evolves, or because the patient or clinician simply forgot about something. This “Oh, by the way...” phenomenon is frustrating because seldom does sufficient time remain for thoughtful evaluation of late topics.

When new issues arise late in the interview, you may need to return to earlier phases of the interview, such as exploring the history, sharing information, and reaching agreement about new plans, particularly if the new information is clinically important. This tends to interrupt or prolong closure. If a new issue is not pressing, both patient and clinician may agree to bring it up at a later visit.

Positive social talk, chatting, laughing, expressing concern, and sharing personal information at the end of a visit may also prolong closure, which is not to say that this is “bad!” This portion of the interaction is when the patient and clinician get to relax and connect on a personal level after the “business” of the encounter is completed.
Preventing closure problems

Use effective interview skills early in interviews to avoid common closure problems. Then transition to specific closing strategies and skills, such as, alerting patients that your time together is drawing to a close, summarizing plans and arranging follow up.

Specific clinician behaviors enacted before the closing phase of the interview help to facilitate effective and uninterrupted closures. These include: (4,5,7)

- Orient the patient to the time frame and tasks of the visit during the early phases of the encounter. (see module 7, “Opens the discussion.”)
- Elicit concerns and ask, “Anything else?” both early in the interview, and throughout it. (see module 7)
- Elicit patients’ beliefs about their illness. (see module 9, “Understands the patient’s perspective”)
- Reach agreement on what should be done about evaluation or treatment of the illness. (See Module 9, “Reaches agreement.”)

Skills that facilitate smooth and effective closure include:

- Alert patients that you are drawing the visit to a close. “We have about 5 minutes left, let’s think about where to go from here.”
- Summarize the visit. “We’ve talked about your symptoms and your exam …as I said, I think we can just wait and watch you closely/treat you with…”
- Review care plans and check for understanding. “So let’s start you on…” “It sounds like you’re willing to give diet and exercise a try first before we begin a new medication…have I got this right?” “What concerns have we not addressed?” “Do you have any further questions?”
- Make plans for interim contact and follow-up. “Let’s make an appointment for you to come back in…In the meantime, if you have any problems or questions I’d like you to call me.”
- Acknowledge the patient by expressing caring, reassurance and salutations until next time. “It was good to see you again.” “I’ll be here if you need help.” “Take care of yourself and say hello to your husband for me.”

Case: Learner B. and Mrs. D:

The learner prepares a smooth pathway towards uninterrupted closure of her hospital visit, and then includes in her closure a summary of what to expect, how to get in touch, confirmation of the next contact time, and a departing salutation.

Learner B. is concluding her admission interview with Mrs. D for diabetes and cellulitis which is not responding to oral antibiotics.
Moving toward closure:

Learner B: “So it sounds like you understand that we admitted you to the hospital because the infection and swelling in your leg seemed to be getting worse in spite of the antibiotics. We’ll also adjust your insulin. I think the resident explained that we plan to do an ultrasound on your leg to be sure there are no blood clots in your leg that could be contributing to the swelling around your ankle, right?”

Mrs. D: “Right. He said that the ultrasound was done with sound waves, not x-rays. It sounded pretty easy.”

Learner B: “That’s right. Did you have any additional questions about the test or the plans?”

Mrs. D: “No, it all sounds reasonable. How long do I have to be in here?”

Learner B: “I’ll check with the team, but I think that if your ultrasound is normal, as soon as we see that your infection is clearing you’ll be able to go home. Maybe a couple of days. Any other concerns?”

Mrs. D: “How will I know what to do about my insulin?”

Learner B: “We’ll go over that with you while you’re here.”

Mrs. D: “Will I be able to get up and walk around?”

Learner B: “We’ll want you to keep your leg elevated while you’re in bed, but if your ultrasound looks clear, you can get up to the bathroom.”

Mrs. D: “Ok. I’ll go nuts if I have to stay in bed.”

Learner B: “I can certainly understand that.”

Mrs. D: “Why do you think this happened? I’ve never had anything like this before.”

Learner B: “I don’t know for sure, but you have a little fungal infection that may have allowed bacteria to get in through tiny skin cracks between your toes. It’s important to take care of that because of your diabetes, so we’re giving you something to get rid of that as well. Did you have some thoughts about what was causing this?”

Mrs. D: “I thought maybe I did wrong by trimming my own nails. My doc keeps telling me to go to a podiatrist but I didn’t have the time.”

Learner B: “Well, that’s certainly another thought, although I didn’t see any cuts or any obvious areas of infection around your toenails. I’ll check again, and maybe we can set you up with the podiatry clinic. Did you have any other concerns or questions?”

Mrs. D: “Not right now but I’m sure my husband will when he comes in.”

Transition and closure:

Learner B: “Ok, that’s fine. I’m finished for now, but I’ll be in the hospital if you want to page me when he comes.”

Mrs. D: “That would be great.”

Learner B: “Good. So we’ll send you to ultrasound and then to your room. Your IV antibiotics are started. You’ll page me when your husband gets here or if you have any questions, and I’ll see you with the rest of the team first thing in the morning. Ok?”

Mrs. D: “Sounds good. Thank you.”

Learner B: “You’re welcome. See you later.”

In this dialogue, the student checks on the patient’s understanding of the reasons for admission, shares information about what to expect next, asks about the patient’s beliefs about what caused her illness, and elicits her questions and concerns three times before she effectively transitions into closure. Learner B’s use of these skills permits her to effectively close with a brief summary of what to expect, how to get in touch, confirmation of the next contact time, and a departing salutation.

CLOSURE OF BRIEF PATIENT-CLINICIAN RELATIONSHIPS
Clinicians must frequently say goodbye to patients, and sometimes you may feel sad about the separation from the intimacy of these relationships, even if the time spent has been (relatively) short.

At all stages of training and practice you will say goodbye to many patients whom you know you will not see again. This will happen in the hospital and emergency room, with consultations and brief surgeries, when cross-covering for colleagues, with clinic patients who are relocating out of town, and with patients who are terminally ill and dying. (Termination of extended clinician-patient relationships will be addressed in Module 36, and saying goodbye to a dying patient in Module 31)

Patients are admitted and discharged quickly from the hospital these days. However, the patients’ hospitalization is the only one they are experiencing and it is a traumatic life event that is accompanied by worry and fears. Patients need to connect with you despite short stays, and especially will appreciate expressions of caring during the time you spend with them. Taking a moment to acknowledge the person, to wish him or her well, and to say goodbye is an expression of respect, and a symbolic marker that the hospitalization experience has concluded. This small gesture of compassion can have a very large effect, and help patients accommodate to illness and move forward into life.

AnnotatedVideo (not shown in print-out text)

CONCLUSION

Effectively closing the encounter depends on both your closing skills and the preparation you do earlier in the visit.

By soliciting patients’ complete agenda at the beginning, attending to verbal and nonverbal clues of patient concerns throughout the encounter, and reaching agreement, the clinician sets the stage for successful closure.

Whether completing a visit or terminating a relationship, the skills of closure will guide you through successful completion of your encounters.

BEHAVIOR SKILLS CHECKLIST

1. Elicit questions and concerns before transitioning into closure.
2. Alert the patient to the fact that the encounter is ending.
3. Summarize and clarify the plans.
4. Check for patient understanding.
5. Arrange interim contact and follow-up plans.
6. Acknowledge your relationship with the patient.
7. Take time to say a truthful and personal goodbye.

LITERATURE REFERENCES

Welcome to DocCom Module 13: Responding to strong emotions: Sadness, Anger, Fear

by Barry Egener, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details
Facilitator Guide of this module for DocCom Residency Doctoring Curriculum

Credits:

Author: Barry Egener, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient (Mr. Hardisson): Josh Silverman
Standardized Patient (Ms. Fuller): Liz Fuller
Angry Father of sick child: Mike Ondri
Clinician on camera: Barry Egener, M.D.
Clinician dealing with angry father: Dennis Novack M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:

3.0 - 12/20/2011 enhanced with MP4 videos and HTML5 code
2.1 - 5/24/2011 Revision by editor
2.0 - 7/8/2009 upgrade to DocCom version 4.0
1.2 - 7/1/2009 revision by Barry Egener
1.1 - 6/10/2007 revision by Geoffrey Gordon
1.0 - 6/27/2005

VIDEO (not shown in print-out text)

Rationale

by Barry Egener, MD

During the medical interview patients' strong emotions tend to elicit strong emotions in their clinicians. Depending on clinicians' skill and self-awareness, those emotions can lead to productive exploration of important clinical issues, or they can threaten therapeutic relationships. This module will describe concepts and skills that help you to respond to patients' intense expressions of sadness, fear, or anger in ways that not only promote patients' healing, but also enhance your own self-awareness and growth as a clinician.

VIDEO (not shown in print-out text)

The Patient's View

VIDEO (not shown in print-out text)

The Doctor's View
Questions for Reflection:

1. In what circumstances are you aware when a patient is feeling strong emotions? In what situations are you caught off guard?

2. How do you respond to patients who get angry with you?

3. When patients demonstrate strong emotions, which of your reactions tend to help the situation resolve? Which tend to escalate discomfort in the room?

4. In your non-medical life, does fear, anger, or sadness tend to cause you the most discomfort?

5. How do you determine whether you need specialty consultations with patients who are emotionally distressed? When do you consult your peers?

Key Principles:

1. Strong emotions can originate in the patient or the clinician, or the strong emotions can derive from the interaction between clinician and patient. Identifying the origin of emotions promotes clear boundaries and enhanced clinical effectiveness.

2. Responding to emotions thoughtfully tends to strengthen the clinical alliance and promote healing; responding reactively or defensively tends to disrupt or weaken that alliance and diminish both patients' and clinicians' satisfaction.

3. Strong emotions in clinician-patient interactions are neither good nor bad. They are a natural human consequence of life-changing events.

4. Exploring clinicians' emotions that arise in the interview as well as the ways that clinicians respond to patients' emotions promotes personal and professional growth.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe the effects (on patients and on clinicians) of clinicians' empathic responses to strong emotions, as well as the effects of ignoring strong emotions.

- Identify likely origins of strong emotions.

- Describe how clear personal boundaries promote clinical effectiveness and professional growth.

- Demonstrate ability to respond empathically to strong emotions.

- Describe situations that may require referral or medication as adjunctive responses to strong emotions.
Identifying Strong Patient Emotions

We often notice strong emotions in patients, but sometimes are so caught up in an interaction that we fail to recognize or respond to patients' emotions (or our own emotions) until we look back on the interaction or notice the residual impact on ourselves.

- **Sadness, Fear and Anger**
  Although they manifest quite differently, the emotions of sadness, fear, and anger all have their origin in the experience or anticipation of loss.

- **Clinician emotions**
  Exploring your own emotions that arise in patient care promotes your professional growth. Most of us are very sensitive to some emotions, and much less to others. You can become a more flexible and effective clinician by being more aware of your own "hot buttons" and "blind spots."

- **Making emotions work for you**
  Empathic responses acknowledge patients’ emotions or experiences, and show your interest in understanding them.

Sadness, Fear, and Anger

The emotions of sadness, fear, and anger all have their origin in the experience or anticipation of loss.

- **In sadness**, the patient experiences directly the discrepancy between a desired and an actual state.
- **In fear**, the patient confronts the agent of an anticipated loss.
- **In anger**, the patient reacts to potential loss by warding off a threat. Anger is sometimes called a secondary emotion, because underneath the anger may be found sadness about the loss.

In the medical interview, each of these emotions can have their source either in the patient, the clinician, or in the interaction between them. We don’t generally associate anger with loss, but when angry, you can uncover this relationship by asking yourself the question, “What might this person (or situation) cause me to lose?”

**What functions do these emotions serve?**

All these emotions have evolved in humans and other species because they confer some survival advantage. Research in wild chimpanzees has demonstrated advantages to the capacity to read emotions as well as disastrous social consequences of the inability to do so. Similarly, people have evolved the capacity to "read" others’ emotions because to do so confers an advantage. Outside of medicine “emotional intelligence” (EQ) may correlate better with job and marital success than intelligence quotient (IQ).

Research indicates that complex neurobiological mechanisms and neuroendocrine activation underlie the phenomenon of empathy. "Mirror neurons" that register observed behavior in the cortex have been identified. These provide the opportunity to internally "rehearse" the observed experience of another person, even if the observer does not perform the action. (Similarly, dreamed actions are suppressed while sleeping.) While the potential to experience another’s experience seems to exist, the degree to which clinical empathy depends on mirroring remains a
research question. (See section below on the interview as healing experience.)

Speculating further on the biology of the emotions is beyond the purpose of this module, but what is abundantly clear is that emotions have effects both on the self and on others. Some neurohumoral effects such as preserving or mobilizing physiologic resources, may be beneficial, and others such as clinical depression dysfunctional. And effects on other people such as engendering the desire to assist can similarly be helpful, while other effects such as provoking anger can be harmful.

Awareness of emotions and the ability to recognize them in other people confers the power to react mindfully rather than reflexively. Thoughtful responses are productive for the patient and satisfying for the clinician, whereas reflex reactions retard rapport and limit healing.

Clinician Emotions

Exploring your own emotions that arise in treating patients promotes your professional growth. Most of us are very sensitive to some emotions, and less sensitive to others. You can be a more flexible and effective clinician by becoming more aware of your own blind spots and "hot buttons".

Emotions are “contagious”

Clinicians may resonate with patients’ anger or sadness and thus feel the same emotion. Or a patient’s emotion may evoke a different emotion in a clinician, e.g., patient sadness may induce clinician anger. Also, a clinician may experience an emotion when the patient is not manifesting any emotion.

The range of responses to patients is as rich as the diversity of human experience, upbringing, culture, and personality. While our own emotions may provide clues to what the patient is feeling, there is nevertheless a differential diagnosis of clinician emotion – just as the emotions may have many sources in the patient, the same may be said of the clinician. These factors combine to attune us differently to emotions – there is no “correct” or “best” response.

Making emotions work for you

Empathic responses acknowledge patients’ emotions or experiences, and show your interest in understanding them.

- Your empathic responses are therapeutic, because feeling understood is healing.
- When you fail to respond, patients may infer that you do not care or value their experiences.
- Your empathic responses help your patients join with you to explore their stories of illness more efficiently.

If emotions are unpleasant or if we lack confidence in our ability to respond to them, we may try to ignore or distance ourselves from them. Seeing the patient as the source of our discomfort can make a therapeutic alliance difficult.

Skillful exploration of patients' emotions, which enables you to understand their situations and increases your capacity for caring, is the main tool in overcoming barriers such as a lack of confidence or discomfort. Seeing the patient as suffering from the emotion rather than being the source of our own unpleasant feeling rekindles a therapeutic instinct. Reminding ourselves that the patient’s behavior is separate from the patient as a person creates professional objectivity.
Further, your exploration usually enhances patients' capacity for healing, as well as their capacity for optimism and for taking effective action.

For me, understanding the patient’s experience is how I overcome the feeling that the patient is a challenge sitting on the other side of the table. It helps me feel that the patient and I are together on the same side of the table, with his uncomfortable experience on the other side.

**The main therapeutic tool is your empathic response to patients' strong emotions.**

Let’s define empathy as most scholars do, as a cognitive awareness of another person’s experience, state, or emotion. Your empathic responses communicate this understanding. The responses show your patients that you are aware of their experiences. Actively demonstrating your understanding builds trust and safety into the relationship. In turn, trust helps patients share more information, and cooperate better with plans and treatments. Data from many sources within medicine, across diverse cultures and in fields such as psychology, education and the arts demonstrate that failing to respond to strong emotions in an empathic manner makes people feel they are not valued, ignored, not understood or not cared for by the listener.

**The interview itself can become a healing experience because being understood is therapeutic.**

You do not need to actually experience the emotion of the patient to imagine how the patient feels. And, to be sure, people debate about how much emotional connection between patients and clinicians is optimal. Too much detachment risks a loss of rapport; loss of boundaries risks a loss of therapeutic agency. My opinion and experience is that it is not necessary to feel what the patient is feeling in order to be therapeutic. However, as discussed above, when I do experience emotion in an interview, I find it useful to become curious about why this is so (see "Professional growth", below).

This module demonstrates application of empathy skills to situations in which emotions are strong. Because of the intensity of the feelings, these could be considered high stakes situations. Nevertheless, empathy skills are the same in simple situations and in emotionally intense ones. Many learners worry that the purpose of empathy skills and empathic responding is manipulative. The aim is, *emphatically*, not to maneuver the patient into another state or perspective desired by the clinician, no matter how benevolent the goal. Rather, the purpose is to become more transparent, to make a genuine clinical understanding more visible to the patient, to build alliance, safety, and trust.

Just as any skill is initially awkwardly performed (think of your first ski run, your first attempt at the Moonlight Sonata, or your first soufflé!), skills become easier with practice, and in many situations even automatic. Increasing the range of situations in which you can respond with empathy is not only possible, it is a process that is essential throughout your career, from student to seasoned clinician. The illustrations in these chapters are necessarily those of the author, albeit informed by the Kalamazoo consensus and other evidence-based sources. They may feel foreign to you – your task is to find personal words that genuinely communicate your attempts to understand patients' experience. Whatever your words, and however awkward or unskilled you feel, if you are genuine in your intention to understand, your attempt will be helpful. First, your empathic non-verbal cues (m14) will be apparent to patients, and secondly, if they misunderstand you are likely to see those signals and have another chance to clarify your intent and express your caring. If your goal were to manipulate, the skills would be inflammatory; if your goal is to communicate genuine thoughts and feelings, no matter how awkwardly expressed, the patient is likely to be appreciative.

---

**Responding to Strong Emotions**

Exploring the emotion accomplishes all three functions of the medical interview: data gathering, relationship-building, and collaborative planning for diagnosis and treatment.
In this section, I will briefly discuss:

- **Responding to intense sadness**
  Giving the patient control over whether and how to discuss the emotion will also give the patient some control of the emotion.

- **Responding to intense anger**
  Anger is a normal response to perceived threat but can be counter-productive when it alienates those who might help.

- **Responding to intense fear**
  Medical events, such as a severe motor vehicle accident or approaching the dreaded end of a lethal illness, can precipitate intense fear.

Although clinicians use judgment in deciding when and how to respond to emotions when they arise in the interview, choosing not to explore emotions that are strongly expressed will usually be destructive to the therapeutic relationship, since a strongly expressed emotion will be apparent and can only be ignored by choice. Ignoring feelings communicates that the clinician does not care about the emotion or considers it not important or relevant to the interview. This greatly diminishes the therapeutic effectiveness of the clinician (Module 3).

In reality, clinicians commonly disregard emotions, sometimes because they think they lack the skills to manage the interview, either in terms of time or emotions, and sometimes because they cannot shift their focus from the biologic aspects of the situation back to the person. Studies have shown that addressing emotions helps shorten the interview and build trust, in both surgical and primary care visits.

I believe that the explanation for the time saving effects of the empathy skills lies in the patient’s persistent attempt to become known as a person, and to communicate important personal needs, values, concerns, and beliefs before proceeding to biomedical concerns. Skillful use of empathy skills allows the clinician to integrate caring for the person with caring for biomedical concerns, as she accomplishes data gathering, relationship-building, and therapeutic goals.

---

**Intense Sadness**

Extreme sadness may be non-verbally apparent as the clinician enters the room – the patient may be crying, withdrawn, or staring at the floor. The clinician cannot initially know whether the experience of loss relates to a health concern, a social issue, depression or something else.

**Giving the patient control over whether and how to discuss the emotion will also give the patient some control of the emotion.**

Thus it can be empowering for the clinician to simply notice the sadness with **reflection**.

“You seem sad (upset or down) today.”

As with all the emotions we will discuss in this chapter, some **calibration** may be necessary. For example, for a patient who is withdrawn, the statement above brings the emotion into the interview and signals that you intend to address it. However, for a patient who is sobbing, the emotion is already present, and the statement above is too tame. Thus, inviting the patient to explain the emotion is a better approach.

“Can you tell me what is upsetting you?”

Some explanation will follow. When the clinician has some notion of the cause, **validating**
patient is the critical next step. (Sometimes the skill of validation is called **legitimation**.) **Validation** demonstrates the clinician’s understanding of the **reason** for the emotion.

“Losing your job when your husband has been out of work must be very upsetting.”  

“It’s terrible to lose a child. Anyone would be terribly distraught.”

The empathy skills **support** and **partnership** offer some help or relief from suffering. **Support** acknowledges a distressing circumstance.

“The last few months of your wife’s illness have been really difficult.”

**Partnership** specifically offers the clinician’s assistance in a distressing circumstance.

“Let’s figure out a couple of options for how to help you feel better, to see what choices fit you best.”

Lastly, **respect** for the patient’s emotional strength can help bolster those resources.

“I’m impressed with how you’ve coped with such a devastating loss.”

Because responding to emotions with empathic communication powerfully signals to the patient the clinician’s interest in staying in relationship even in the presence of strong emotions, we discuss this dynamic in many modules, and notably in M 6, on **Building Relationship**. The need for clarity during discussion of medical topics sometimes distracts clinicians from responding to the patient’s sadness or other emotions. The mnemonic **PEARLS**, representing **Partnership**, **Empathy**, **Apology** (or **Appreciation**), **Respect**, **Legitimation**, and **Support** helps many clinicians find words to respond in complex or stressful situations.

---

### Intense Sadness: other considerations

**Depression**

Many (but by no means all) people who suffer a significant loss or illness will develop clinical depression. Whenever strong sadness is present, the clinician should screen for the presence of major depression. In extreme sadness, the clinician should explore the patient’s capacity for self-care (or intent for self-harm) and access to a support system: friends, relatives, faith, and other practitioners.

**Professional growth**

Self-awareness is critical not only for the self-care and growth of the clinician but also to be maximally effective with the patient. How a clinician’s own emotional state will be affected by a distraught patient will have been to some extent conditioned by the clinicians’ formative life experiences as well as by similar previous clinical encounters.

One common response would be personal sadness. The self-aware clinician will consider the possibility that his own sadness is a diagnostic clue to the presence of sadness or depression in the patient. [see Clinician Emotions].
Intense Anger

Anger is a normal response to perceived threat but can be counter-productive when it alienates those who might help. Further, if clinicians respond with defensive or retaliatory statements or questions, patients' anger may actually increase. Remember this key factor: you can express your understanding without agreeing with patients.

Patients may express anger toward clinicians for many reasons, including:

- **medical errors**, by the clinician or any part of the medical team
- clinicians' appearing uncaring, arrogant, or judgmental
- sometimes the patient is fearful or angry about his medical situation but directs that anger toward the medical team

Click the picture above to see a movie portraying poor communication with an angry patient.

Click the picture above to see a movie portraying better communication with an angry patient.

Most clinicians find it difficult to try to understand and to express empathy with patients by whom we feel attacked, but the same skills useful in other situations are equally useful here. As with sadness, stating your empathy with angry patients may require calibration. For example, when the patient is “simmering” with anger but doesn’t feel that it’s appropriate to reveal the anger, **reflection** will help bring the upset into the interview, where it can be addressed:

“You seem angry. Have I done something to upset you?”  

*Reflection*

However, the same statement would seem foolish, sarcastic, or belittling to a patient who is yelling at the clinician. Here, there is no need to bring the emotion into the open, since it is already present. **Validation** would be more appropriate:

“Anyone would be upset after being kept waiting in a cold room dressed in a flimsy gown.”  

*Validation*

Clinicians are often reluctant to **validate** (or **legitimize**) a patient’s anger for fear of “adding fuel to the fire.” But especially because *not feeling heard* often arouses patients’ anger, legitimizing (validating) the feeling is helpful, not harmful.

The “I can understand that you . . .” language enables a clinician to **validate** a patient **while not** necessarily agreeing with the patient:

“I can understand that you would be upset with me for not prescribing the Vicodin®, when that’s the main reason you came in today.”  

*Validation*
YOU DON’T HAVE TO AGREE TO EXPRESS UNDERSTANDING!

It is still possible to support a patient who is angry:

“It’s difficult to care so much and feel that you can’t control what happens.”

“Let’s see if there’s another way I can help address your concerns; or perhaps others on the health care team can assist us.”

When the disagreement transpires within acceptable bounds, respecting the autonomy of the patient can de-escalate anger:

“Even though I’d prefer that you agree with the team’s recommendation, I respect that you need to advise your mother of what you consider to be in her best interest.”

One of the challenges of dealing with intense anger is balancing empathy with enough “detachment” to remain professional. The patient’s anger may or may not be directly towards us personally, but feeling personally attacked can make us defensive. And acting defensive worsens the situation, because it escalates rather than de-escalates the emotion. Sometimes it helps to remind ourselves that although patients’ anger may be directed at us, its origin may lie in the patient’s circumstances. In other words we’re not responsible for the patient’s anger or for “fixing” it. However, we do help patients when we take the time to become mindful of their pain or loss and genuinely attempt to make an empathic statement despite feeling attacked.

Intense Anger: other considerations

Boundaries and safety

There are times when it is appropriate to place boundaries on the patient’s anger, when you would choose not to empathize, such as when the patient is so upset that he cannot listen, when the patient has lost control, or when he threatens the safety of those around him. The best way to place limits on the patient is to describe the conditions in which you are willing to continue to engage him.

This gives the patient the choice of whether to de-escalate the confrontation and continue to be heeded or, alternatively, to lose his audience and certain other freedoms: “I’m willing to continue this conversation so long as you exhibit the same respect towards me that I am giving you.”

If disregarded, your own limit-setting should escalate: "If you continue to disrupt our ability to conduct care safely in this clinic, I will need to call Security.”

If the patient continues to be disruptive, it’s best not to continue to engage him. Doing so may indeed “fuel the fire.” In such situations, it is appropriate to leave the room, to hang up the telephone, or to call Security.

Your own safety takes precedence over being therapeutic. Your own gut feeling about personal safety is generally reliable, and being attuned to a sense of danger is but another aspect of self-awareness.
Exhibitions of extreme anger are unusual and may signal other feelings or diagnoses. For example, intense anger may be a way of insulating oneself from intense fear, such as that presented by a lethal diagnosis or a threat to one’s child. Anger that might have been more moderately expressed can be dis-inhibited by alcohol and other drugs. Personality disorders and delusional thinking can manifest as extreme anger, so such demonstrations should prompt consideration of substance abuse, sociopathy or schizophrenia.

**Professional growth**

Being the target of intense anger is always upsetting, and you are likely to feel shaken. Take a few moments to center yourself after such an encounter before moving on to other tasks and reflect on the experience, which may offer opportunities for growth. You could ask yourself, or discuss this with a trusted colleague:

- “What was going on here at a deeper level than what the confrontation was about?”
- “What might I have said or done that could have de-escalated the situation?”
- “Was there anything I did that increased the patient's anger; or did I set it off in some way?”

---

**Intense Fear**

Medical events such as a motor vehicle accident or a worsening clinical situation precipitate intense fear. You can best assist patients who experience intense fear by helping them bring the fears into the interview where you can listen and show your understanding.

We need to resist invoking false reassurance in order to minimize the patient’s or our own discomfort. When a patient's fear is well-founded, false reassurance jeopardizes trust and undermines the therapeutic alliance. That alliance is what provides the leverage for supporting the patient. On the other hand, you should never diminish hope. Even when the most dire outcome, death, is certain, hope may be available in the manner or management of dying, in spiritual domains, and in the people and accomplishments left behind.

Starting with what you observe may objectify an emotion of which the patient was consciously unaware:

“You seem apprehensive.”  
*Reflection*

Then explore the cause:

“What worries you most about this illness? operation? dying?”
“What help would you like in order to deal with [whatever the patient names]?”
“What worries you most about leaving your [significant other] behind?”
“Have you spoken to her of your concerns? Are there ways you could provide for her?”

Many of the concerns patients will name can be addressed:

- If a patient fears uncontrolled pain, you can **reassure** her of the effectiveness of and access to medication.
- If the patient has spiritual concerns, you can consult appropriate **pastoral services**.
- Sometimes simply **naming the fear** or hearing that particular concerns are normal rather than extraordinary, diminishes fear.
- Since a lack of control over future events drives the intensity of fear, **taking any positive action** may confer a sense of control.

The interview itself can offer several ways of helping the patient. Commonly, a sense of isolation,
of having to face the unknown alone, intensifies fear. Feeling unattractive or tainted by illness can increase a sense of alienation. Sometimes the patient’s specific fears are realistic and terrifying, such as the new diagnosis of a lethal disease. In these situations, the expression “I wish it were different” can support the patient by communicating caring, understanding and sharing the patient’s perspective. Knowing that many others have been in the same position can help:

“The experience of chemotherapy is scary for patients. They commonly think that others fear being around them.”  

“You’re dealing with a lot right now.”  

“And you’re doing very well with it.”  

You can alleviate that sense of isolation by offering to refer the patient to a counselor, to a support group, or simply by proffering your own constant presence:

“Whatever struggles you’ll face with this illness, we’ll go through them together.”  

**Intense Fear: other considerations**

**Other resources:**

Some patients’ fear becomes a paralyzing terror, preventing them from making constructive steps. Anxiety is a psychobiologic consequence of fear. While anxiety can mobilize a patient to prevent or mitigate a feared event, severe anxiety may require psychiatric consultation or medication. If appropriate, a benzodiazepine can give the patient relief and a sense of control. Remember to screen for alcohol or other substance abuse before you offer this option.

**Professional growth**

You confront your own existential fears through your patients’ suffering and death. Many clinicians in certain specialties encounter these challenging issues every day. You also bump up against your own limitations, which can precipitate a professional crisis. Reflecting upon these issues with colleagues lessens feelings of isolation, guilt, inadequacy and uncertainty which all caring professionals live with, and bringing fears into the open prevents burnout. No one is immune to these experiences—remember to share feelings with your colleagues and your team; their listening will help you at the same time it helps them.

**CONCLUSIONS**

Because patients regularly confront both real and apparent life-changing medical events, clinicians will regularly encounter their patients’ and their own strong emotions. These emotions are neither good nor bad—they are simply facts, like the weather. And like the weather, they will change as circumstances evolve.

Both patients and clinicians can become stuck in emotions, and overwhelmed by their force. At
these times we must maintain our own professional equilibrium and use the skills that we have practiced in less challenging circumstances, particularly those empathy skills that communicate interest in the patient as a person.

The intensity of these moments can generate proportionally strong and rewarding relationships with patients. Similarly, such moments not only create professional challenges, they also engender personal and professional growth.

---

**Behavior Checklist**

- Observe non-verbal clues to patient emotions
- Maintain professional demeanor in the presence of strong emotion
- Use empathy skills: partnership, reflection, respect, validation (legitimation), support, (PEARLS)
- Calibrate your response to emotions
- Explore the sources of patients' intense emotions
- Reflect upon your responses to patients' emotions

---

**References**

Welcome to DocCom Module 14: It goes without saying...

by Jeannette M. Shorey II, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Author: Jeannette M. Shorey II, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Acting as Patient with gown: Dennis Novack M.D.
Acting as Patient with green shirt: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient: Eileen Ert
Clinicians on camera: Cecile A. Carson, M.D. and Jeannette M. Shorey II, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Rationale
Cecile A. Carson, MD

Just what is “nonverbal communication”? It is useful to think of it as all the behavioral signals that go on between interacting individuals, exclusive of the verbal content. When two or more of us are together, we human beings cannot fail to communicate at all times, even when we are silent.

Questions for Reflection:

1. How did your parents use voice tone to communicate their feelings to you?

2. Think about a recent conversation with a family member or significant other. What nonverbal communication did you observe? What do your interpretations say about the other person, and what do they say about you?

3. How do you feel if people get too close physically when they speak to you?

4. What non-verbal behaviors signal that the person feels safe and comfortable listening to you?

5. How can you use your own non-verbal behaviors to help people feel more comfortable and willing to listen to you?

6. What are your non-verbal behaviors when you get angry? What are they when you feel frustrated? What are they when you feel secure or confident?

Key Principles:
1. People continually send and receive nonverbal messages
2. First impressions are based on nonverbally communicated information
3. Both patients and doctors send mixed messages. The nonverbal component reflects the speaker’s feelings better than a conflicting verbal component
4. The four categories of nonverbal communication are kinesics, proxemics, paralanguage, and autonomic changes
5. In conversations with patients, the key nonverbal information is whether they appear to feel “safe” or “not safe”
6. Leading and matching behaviors are natural and usually unconscious
7. The most important nonverbal skill is building nonverbal rapport

Learning goals:

At the conclusion of this module, you will be able to:

- Describe four categories of nonverbal communication
- Describe four patterns of nonverbal behavior seen in medical settings
- Describe four types of proxemics (shaping space) that foster rapport
- Discern and name nonverbal behaviors in video clips in this module
- Demonstrate ability to match and lead during conversation

INTRODUCTION

Let’s define “nonverbal communication” as all the behavioral signals that go on between interacting individuals, exclusive of the verbal content (1). When two or more of us are together, we human beings cannot fail to communicate at all times, even when we are silent.

- **The importance of nonverbal communication**
  Nonverbal communications are powerful and useful. The “first impressions” that we clinicians make of patients, and that patients make of us are based almost entirely on nonverbally communicated information.

- **Rapport**
  Rapport simply means “I am with you,” and is the nonverbal structure of empathy

- **Nonverbal behavior and feelings**
  Involuntary nonverbal communication more accurately reflects the feeling state of a person than does a verbal message.

- **Monitoring the interview**
  Tracking nonverbal communications has special utility when you are puzzled about some
aspect of your relationship with a patient.

The importance of nonverbal communication

**Nonverbal communications are powerful and useful.** The “first impressions” that we clinicians make of patients, and that patients make of us are based almost entirely on nonverbally communicated information.

All of us are sending and receiving nonverbal messages all the time, at varying levels of subliminal and conscious awareness. Some of us naturally monitor the messages. All of us can learn to attend to them.

Experts’ estimates in the literature range widely, but on average, they teach us that 80% of all communication is nonverbal and involuntary, while 20% is verbal and under our conscious control. Important information - that cannot be hidden - is being exchanged nonverbally at all times from patient to clinician, and from clinician to patient. For both parties, the nonverbal channel carries the meaning of the message while the verbal channel carries the more concrete content of the message. There is much to be gained by tuning in to these nonverbal messages.(2) This takes some practice, but once you become attentive and skillful, obtaining this valuable information takes no extra time.

Evidence shows that nonverbal communication has significant influence on the important outcomes of patient satisfaction, adherence to medical advice, and even clinical response to treatments. (3,4)

Rapport

**Rapport simply means “I am with you,”** and is the nonverbal structure of empathy.

Rapport is sensed almost entirely nonverbally. Experienced clinicians know that their work with patients is more efficient and more effective when both parties are in good rapport. In that harmonious state, historical information can be gathered more fully and accurately, therapeutic plans can be more easily negotiated, a clinician’s advice is more apt to be followed, and both people are more satisfied with the exchange. Fortunately for clinicians and patients, good rapport can almost always be initiated easily if we pay conscious attention to our nonverbal messages.

Nonverbal behavior and feelings

Involuntary nonverbal communication more accurately reflects the feeling state of a person than does a verbal message.

The nonverbal components of communication help give meaning to our spoken words and help us interpret how our words have been received. The full meaning of a communication can be found in the response a message evokes in the receiver (e.g., the patient). The patient’s verbal and nonverbal responses may show you that s/he has interpreted your message exactly as you had hoped, or your patient’s responses may surprise you by indicating that s/he has interpreted the message in a way other than what you intended to communicate. Getting a response different from the one you expected does not mean that your communication was bad. It just means it did not do the job you wanted it to do. You have not yet made your message clear. You may need to be flexible and find another approach – perhaps verbally and nonverbally – in order to
Involuntary nonverbal communication more accurately reflects the feeling state of a person than does a verbal message. In other words, it’s hard to be dishonest nonverbally. If you perceive a mixed message from a patient, the nonverbal channel sends the truer message. Similarly, if a patient perceives a mixed message from his/her clinician, s/he is likely to put more credence in the clinician’s nonverbal message. For example, if a clinician asks a question of a patient while maintaining eye contact, then turns to the paper or electronic medical record before the patient has begun to respond, it is quite possible that the patient will interpret the nonverbal message of breaking eye contact to mean that the clinician is not genuinely interested in the patient’s response to the question. The clinician may feel confident that s/he can look at the chart and listen to the response at the same time – but the patient may not share that perspective. It is certainly not necessary to be looking at the patient throughout his/her entire response, but it is helpful to support the beginning of the response with continued visual connection, and you should maintain that connection if the patient is expressing strong affect.

Monitoring the interview

**Tracking** nonverbal communications has special utility when you are puzzled about some aspect of your relationship with a patient.

Paying attention to the nonverbal communications that are flowing between clinician and patient allows either party to track the **process** of how the interaction is going for them. If things are not going well, the attentive clinician has a choice. S/he can bring the apparent difficulty into the “open” in terms of conscious, verbal discussion, or s/he can try to make more subtle shifts to improve nonverbal rapport. We will pay much more attention to the topic of building nonverbal rapport later in this module.

All behavior is communicating something, and all behavior is adaptive. A patient’s behavior does not occur in a vacuum, but rather is an adaptive response to his/her unique world view. We may not be able to recognize immediately the adaptive purpose of a particular behavior, especially if it is self-destructive. However, recognizing that every behavior has some kind of adaptive purpose may allow us to stay on the “same side of the fence” with the patient, rather than becoming judgmental and pulling away. This stance also allows the creation of a therapeutic alliance that can help the patient change the behavior.

**FOUR CATEGORIES OF NONVERBAL COMMUNICATION**

The four categories of nonverbal communication are **kinesics** (movement), **proxemics** (shaping space), **paralanguage** (pitch, tone, volume), and **autonomic** (physiologic changes from the autonomic nervous system).

**Kinesics** refers to behaviors that involve movement, such as facial expressions, eye gaze, levels of body tension, gestures and fidgeting, how and where we touch each other, and body position (or posture). These are typically nonverbal behaviors over which we have some degree of voluntary control.(5)

**Proxemics** refers to how the space is shaped between interacting individuals, and includes vertical height differences, interpersonal distance, angles of facing, and physical barriers such as charts, computers, desks, and exam tables.

**Paralanguage** includes all the qualities of the voice: tonality, rate, rhythm, volume, and emphasis.(6) Not only can we use these qualities to deliver quite different messages with the
same words: I am ordering these tests; vs. I am ordering these tests; vs. I am ordering these tests – but we each have our own unique voiceprint, much like our fingerprint, that often lets others identify us immediately when we phone, even before we tell them who it is that is calling. A warm and inviting voice – on the phone or in the office - can create relaxation and comfort in a patient, and help them more readily talk about their primary concern. Attending to paralanguage is also very helpful in telephone medicine where the only nonverbal cues are in the auditory domain.

**Autonomic changes** are truly involuntary nonverbal signals that reflect alterations in a person’s internal state. Facial color can shift from neutral to flushed or blanched. The conjunctivae can begin to glisten as an early sign of tearing. You can see sweating or feel it in a handshake. You can notice whether a person is breathing calmly, sighing, or taking in a deep, startled breath. Pupil size dilation and constriction can be observed if the iris is a light color. Changes in these autonically controlled signals usually reflect strong feelings, worthy of your notice. These signals may provide you with clues and cues to the patient’s significant health concerns and/or information about how the patient is feeling about you and what you just did or said.

---

**FOUR GENERAL PATTERNS OF NONVERBAL RESPONSE IN CLINICAL SETTINGS**

Since it is possible to observe hundreds of bits of nonverbal data, developing a cognitive framework to sort the data and identify patterns of behavior is a useful learning strategy. Four patterns are particularly important to detect.

- **Safe pattern**
  In safety, the predominant feature is that the body is engaged, relaxed, and in an *open posture*.

- **Fight pattern**
  In “fight,” the predominant stance is one of *engagement*, and of attack or retaliation as a defense to feeling unsafe.

- **Flight pattern**
  “Flight” is characterized by increased body tension, as in “fight”, but shows *disengagement*, rather than engagement.

- **Conservation-withdrawal pattern**
  In “conservation-withdrawal,” the person is overwhelmed with excessive input and is *withdrawn*, unable to mount a response.

**Some exceptions to the patterns**
Patterns are often mixed rather than occurring in “pure culture.” Also, nonverbal communication differs across cultures, with the major exception that “safe” and “not safe” seem to be universal patterns.

---

**Safety**

In the context of a doctor-patient visit, **the most important distinction that nonverbal signals can help you make is whether the patient appears to feel "safe" or "not safe."** "Safe" is relaxed or neutral, compared to "unsafe" which is activated (fight or flight) or
withdrawn (conservation-withdrawal).

Safety is a basic human need, and is about self-protection and self-preservation. When we humans feel safe, our catecholamine levels are relatively low. We can hear what is being said to us. Our brains are able to absorb a broad range of information, process the information, and produce new thoughts and questions. When both patient and doctor feel safe, they are in the best state to accomplish productive work. In other words, the patient needs to feel safe enough to reveal real concerns, fears, and vulnerabilities to their clinician; and then be psychologically available to hear, see and react to the doctor’s responses. The clinician needs to feel safe enough and “present” enough (not fearful, distracted, or anxious) to hear the patient’s story medically and psychosocially, and then to respond with all of his/her medical and human insight.

If safety is not present for the patient, s/he will reveal “not safe” behaviors which are most commonly those of “fight” or “flight.” A less common response is “conservation-withdrawal.”(8) Each of these has characteristic nonverbal features of kinesics, proxemics, paralanguage, and autonomic shifts. It is therefore possible for you to read quickly the patterns of each response. We’ll look at each these patterns in static form on the next several pages, and then in action on the video clips.

Safe pattern

In safety, the predominant feature is that the body is engaged, relaxed, and in an open posture.

People who feel safe show reduced body tension, reduced interpersonal distance, and relaxed facial muscles. Arms and legs are relaxed as well, and typically uncrossed. There is variation in gestures and in voice tones, as the sense of safety gives rise to freer expression. Facial color is neutral and other autonomic signals are generally “quiet.”

This person appears relaxed in face and posture, as if about to speak, and her crossed legs may or may not be an important gesture at this time.

Fight pattern

In “fight,” the predominant stance is one of engagement, and of attack or retaliation as a defense to feeling unsafe.

In full expression, it looks like a “raging bull.” Typical nonverbal signals of fight include heightened body tension, leaning forward with jutting jaw, clenched fists, narrowing of the inner eye brows, flaring of the nostrils, and tensing of the mouth. Voice volume typically increases and becomes more staccato, and breathing is deeper. The face may flush.
This person’s posture is forward, her jaw juts out tensely, and her nostrils may be flared. Her posture shows tension in arms, legs and right hand is clenched on her knee. Her face may be flushed.

This person’s jaw juts out and her entire face is tense, with flared nostrils and flushed face.

**Flight pattern**

“**Flight**” is characterized by increased body tension, as in “fight”, but shows disengagement, rather than engagement.

Characteristics of the flight pattern are easy to remember because everything flees nonverbally: the person may pull back or tuck the chin, turn the head and avert the eyes; barriers of crossed arms and legs may go up; the voice volume diminishes and speech may be strained or hesitant; color may blanch, and breathing may be faster, more shallow, or held.
This person is leaning away from the desk, her arms are crossed, her chin is tucked in and her face more relaxed than tense.

**Conservation-withdrawal pattern**

In "conservation-withdrawal," the person is overwhelmed with excessive input and unable to mount a response.

The nonverbal cues are disengagement and relative immobility. The still body is slumped with sagging face and limbs; the voice is very soft and speech is hesitant when present; color is more neutral, neither flushed nor blanched; barriers are down. This pattern is well known to experiencedclinicians as the look of a patient with marked depression, and the look of someone who is emotionally and physiologically overwhelmed in an intensive care unit.

This person is slumped down with slack arms; her eyes are closed or looking very downward.

**Some exceptions to the patterns**

Patterns are often mixed rather than occurring in "pure culture." "Safe" and "not safe" seem to be universal patterns across cultures, while other nonverbal communication differs in diverse cultures. Similarly, facial expressions of fear, anger, disgust, grief, surprise and joy seem to be consistent across diverse cultures. (9)

Having looked at all four behavior patterns, we need to qualify these general forms by noting that it is important to read the overall pattern of nonverbal responses rather than to rely on any one signal. Patients may cross their arms because the room is cold, or because there are no arms on the chair – yet their bodies remains quite relaxed and engaged and their voices are melodious, indicating overall safety in the encounter. You may see a flushed face and hear a loud voice as a
patient describes being angry with someone else in his/her life, while s/he is actually feeling safe enough with you to share the story.

It is also important to note that you will frequently see mixed responses, such as fight and flight, especially in patients who are angry with us but are afraid to jeopardize the relationship by telling us. Such a patient might show us an angry face but his body might be pulling away and his arms might be crossed.

Another caveat is that there is important cultural variation of some nonverbal behaviors, with different significance attached to gestures, eye gaze and eye contact, and to norms about interpersonal distance and touch. Eye contact, for example, is a behavior that is generally appreciated as a sign of engagement and attentiveness in cultures of Western European origin, while sustained eye contact is viewed as rude and disrespectful in Asian cultures of Chinese derivation.(10) Being ready to have conversations with our patients that help us explore and learn from them - when we sense misunderstanding of some behavior - is key to good relationship-building across cultural differences. ( m 15)

BUILDING NONVERBAL RAPPORT

Rapport simply means “I am with you,” and is the nonverbal structure of empathy. Some researchers have called it “interactional synchrony.” We think building nonverbal rapport is the single most important nonverbal skill. We can create or deepen rapport by matching and leading patients’ nonverbal behaviors.

Building rapport helps create the form or vessel in which to hold the therapeutic clinician-patient relationship. It consists of two parts: matching and leading.

- **Matching**
  Matching is the process of mirroring aspects of the other person’s behaviors, in such a way as to acknowledge and reflect the state they are in.

- **Leading**
  Leading is the utilization of the interactional synchrony that has been set up by matching.

**Video Clip**
Click the link above to play a video clip to hone your observational skills

Matching

Matching is the process of mirroring aspects of another person’s behaviors. The patient who is "matched" usually feels that his emotional state is acknowledged and understood by the clinician.

When matching, you join patients in that state. You can match anything you notice: facial expression, voice volume and rate, body posture and gestures. As you begin to create synchrony with the other person, you quite literally begin to enter their world nonverbally. Patients unconsciously recognize this nonverbal acknowledgement, although consciously they usually just report a sense of being “understood.” Matching is the nonverbal equivalent of the verbal empathy skills of "naming an emotion," "mirroring" or "reflection," and nonverbal matching is empathy in action rather than in words. The alliance-building generated by the nonverbal signals is at least as
powerful as words that express empathy, and often builds even more trust and safety.

Strive to be graceful and respectful in your matching, and to match only enough so that what you are doing does not come into the patient’s conscious awareness. Otherwise, the patient will feel mocked rather than supported.

We humans often slide into matching each other completely unconsciously. Turn off the sound sometime when you are watching a live television broadcast. You can easily see the spontaneous postural matching of characters who are in rapport – and the postural mis-matching of individuals who are out of rapport.

---

**Leading**

Leading is the utilization of the interactional synchrony that has been set up by matching.

Like dancers, two people in rapport are motivated to stay that way. Therefore, a leading motion by one person of a pair will quite likely invite a reciprocal response in the other person.

For example, if the patient across from you appears to be feeling “not safe” - sitting upright with arms crossed - and you choose to mirror this subtly in your own posture by sitting more upright, the patient may feel met and more understood. When you have matched this posture for a few moments, you can begin to lean in a bit more toward the patient and notice whether the patient follows. With practice, if you discover that your patient appears “not safe,” you can match an aspect of her behavior and try to lead her to “safe” - the state in which mutual understanding can more easily be achieved.

As you are introduced to the concepts of leading and matching, you may worry that we are suggesting that you become duplicitous or manipulative and “trick” patients in some way.

We emphasize that we are asking you to become conscious of leading and matching activities and skills that are entirely natural but usually unconscious (as in dancing). Using these skills will improve your ability to serve your patients more fully and directly. We understand learning these skills to be the same as learning new verbal communication skills, in order to inform and guide patients more effectively. As discussed in modules 6 and 13, building and maintaining rapport is an essential aspect of your ability to effectively engage patients in collaborative partnerships that promote healing and health.

---

**Videos to practice your observational skills**

**Example 1:**

View this video clip to practice your observational skills.
Quiz Question:

Do you think the patient has more on her mind that she would have liked to have said?
What specific nonverbal behaviors did the doctor engage in that discouraged the patient from bringing up her concerns?

Click the hyperlinks that apply - and receive feedback:

Answer 1: Their relative postures.
Answer 2: The clinician’s voice tone and rate of speech.
Answer 3: The clinician’s visual attention to the patient.

Example 2:

Now view the continuation of this interaction to see what happens next

Discussion:

Note that the clinician’s eye contact is now congruent with her verbal and other nonverbal messages, and the patient feels safe enough to overcome her initial nonverbal disengagement and proceed to speak about her additional concern. The course of the visit looks like it’s going to be different from the prior example. The patient’s disclosure may extend the length of the visit. However, the clinician now has the option of prioritizing the agenda for the visit so as to include discussion of the additional concern without lengthening the visit. If the concern is not noted by the clinician, it might become a “doorknob” concern that lengthens the ending of the visit, or leaves the patient very unsatisfied.
(See DocCom module 07: "open the discussion")

SHAPING SPACE FOSTERS RAPPORT

You can use several components of proxemics to foster rapport and safety in the doctor-patient relationship.

- **Setting the stage**
  relates to welcoming the patient to the medical encounter.

- **Vertical Height Differences**
  relate to important power differentials in clinical encounters.

- **Interpersonal Distances (the horizontal space between us)**
  relates to "ownership" of the territory of the encounter.

- **Angles of Facing**
  relate to alliance in the relationship.
**Physical Barriers**
relate to feelings of protection or exclusion.(11)

---

**Setting the stage**

Every bit of the outside and inside of your offices and hospitals can give a message of invitation or dis-invitation.

You can arrange space to encourage access and comfort – which, in turn, helps both patient and doctor to relax, and feel safe.

How a clinician arranges and uses the spaces of his/her waiting room, consultation rooms, and exam rooms has significant influences on the experiences people will have in those rooms. If you haven’t already toured your office spaces pretending to be a patient, we highly recommend this exercise. Sit in all the chairs in which your patients may sit. Lie down on the exam tables. Try on an exam gown. Take a look at whether desks, tables, computers and book shelves create spaces in which you feel comfortable from the patient’s perspective. Are any of those pieces of furniture forming barriers that separate patient and doctor in ways that do not support effective exchanges? Does the art on the walls reflect your taste? Is it likely to appeal to the majority of your patients? Do you provide reading material that is apt to be useful and/or appealing to the majority of your patients? And does the literacy level of the reading material span the literacy range of your patients?

---

**Vertical Height Differences**

You can minimize the negative effects of power differences by minimizing differences in vertical position.

Vertical height differences can quickly create or reinforce feelings about power and control. Add to this the facts that patients often feel vulnerable when meeting a new clinician, and fearful if they suspect the possibility of a serious illness. Be willing to match a patient’s eye level, or even to seat yourself so your eyes are lower than the patient’s. This will nonverbally offer your support and the reassurance that you are there to be helpful, not controlling.

**Example 1:**

Check out the video on the left. How do you think the vertical posture of the clinician influences the patient’s communication?

**Discussion:**
In this video the patient does not say anything. The clinician seems rushed, and her nonverbal behavior could be interpreted as “I am in charge, and I have important business elsewhere.”
Example 2:

Check out the other video on the left.
How do you think the change in vertical height influences the patient’s communication?

Discussion:
The patient seems to have found a voice, perhaps because the clinician has sat down and remained fully attentive. How do you think the change in posture influences the clinician’s communication? We cannot know if the clinician’s initial intent in sitting down was to go more slowly, or if sitting allowed her to go more slowly, but she certainly leaves more space for the patient to ask questions. We must sometimes talk with patients who are lying in bed – whether a hospital bed, an emergency room stretcher, or the patient’s bed at home. How we place ourselves in relation to supine patients can greatly affect both our comfort and theirs. This in turn will affect the ease with which our verbal exchange can occur. Towering over someone creates nonverbal hierarchy that discourages patients from asking questions and voicing concerns. It is always preferable to sit down when speaking to a patient in a bed. Sitting down also conveys to the patient a sense that you have the time to listen. It is also preferable to sit on a chair, rather than on a patient’s bed, since sitting on the bed may “crowd” some patients uncomfortably and convey disrespect to others.

Interpersonal Distances
(the horizontal space between us)

Adjust your distance from the patient according to signals of safety.

A third way to work with spatial relationships is through interpersonal distance. If you are too close during an interview, the patient will feel that his space has been encroached upon, and is likely to behave in ways intended to restore the proper distance – such as looking or turning away, crossing arms and legs to put up a “frontal barrier,” or flushing. Being too far away discourages true engagement, and may convey a sense of disinterest to the patient.

Example:

Check out the video on the left.
Note what signs of flight indicate that the clinician is too close for this patient’s comfort.

Discussion:
In this video clip the patient attempts to move back in his chair and crosses his arms. He does not speak during a pause in which he would likely offer more data, a question or a comment if he felt safe.

### Angles of Facing

**Adjust the angle** at which you face your patient so as to emphasize collaboration; move more towards a side-by-side position rather than opposite each other.

The fourth component of shaping space is angles of facing. Consider that opponents “face off” against each other. Colleagues or partners tackle challenges together “shoulder-to-shoulder,” or “side-by-side.”

When you are examining information with a patient, e.g., laboratory results, you can create a greater sense of collaboration by sitting more side by side than opposite each other. The lab results can be positioned in front you both, rather than being "the problem" in between you. Sitting on a chair or stool on rollers can be very helpful in joining spatially with your patient when you feel that is appropriate.

Imagine a different set of circumstances, for example, when you need to recommend a life-style change that is not what your patient wants to hear. You disagree. If you are seated directly opposite each other, you and your patient may experience the difference as more of a confrontation than is actually intended. Once you are aware of this sense of confrontation rather than collaboration, you can begin to diffuse it by slowly changing the angle at which you are facing each other. Just a slight angulation can begin to ease the tension. Moving to an even more side-by-side position can generate feelings of support and collaboration, in spite of the disagreement.

### Physical Barriers

Show your interest in staying in connection by adjusting your position with regard to potential barriers.

The fifth component of space we’ll examine is that of physical barriers. These can be crossed arms and legs, a desk, a chart, a computer, an exam table or any other piece of furniture or equipment. How can we work with them? We can go around them, work around them, move them out of the way, comment on them if they are fixed, and do absolutely nothing about them if the barrier proves useful to the patient and the doctor. The key is our awareness of them, and our efforts to stay connected with our patient.

**Example 1:**

Check out the video on the left. How does the barrier of the computer on the clinician’s desk effect the communication in this movie?
Discussion:
The clinician and the patient have trouble making eye contact. The clinician seems to be preoccupied with the keyboard. The patient, without eye contact, seems distracted and not attentive to the clinician. He offers short responses after her verbal questions, but does not expand his story or relate to the clinician during her silences.

Example 2:

Check out the other video on the left.
How does the clinician’s noting the barrier of the computer and aligning side by side with her patient effect the communication here?

Discussion:
Both clinician and patient seem attentive to each other in spite of the computer. The conversation flows, with voice modulation and body movements that indicate relaxation and engagement.

AVOID MIXED MESSAGES

Create safety by assuring congruence of your verbal and nonverbal communications, and attend to any non-congruent communications from your patients to you.

We’ll now put several of your nonverbal skills together to help you work with your patients in ways that can literally “save the day,” save the relationship, and save important outcomes of visits – by bringing your attention to the mixed messages that so often flow between patients and doctors. "Congruent" communications demonstrate a synchrony between the verbal and nonverbal behaviors. The words and the behaviors that go with the words send the same signals to the other person.

"Non-congruent" or mixed messages occur when the words and the nonverbal behaviors do not agree. This happens, typically, when a person feels conflicted about expressing feelings directly. This conflict arises when people do not feel safe enough to say how it really is between them. Both patients and doctors send mixed messages. For each party, the nonverbal component of the message more truly reflects the speaker’s feelings in the moment. When you wonder out loud why your patient looks "worried" and says she is "fine," you are addressing the non-congruent verbal and nonverbal signals - the mixed message. This usually helps the patient feel safe enough to convert an incongruent “fine” to a congruent “well, actually I was . . .”

You express interest and concern when you notice patients' non-congruent messages. Your willingness to explore them enhances rapport, cooperation, collaboration and facilitates healing. A second common scenario is a patients' reluctance to take medicine or undergo some test or treatment. This might be addressed by "validating" or "legitimizing" the patient’s non-congruent expressions by saying, "Many patients about to take a new medication have concerns about it, such as cost, side effects, working it into their daily schedule . . . ."

Perhaps the most common non-congruent message from clinician to patient is around reassurance. The clinician says, "you'll be fine," and has an expression of sadness or withdrawal.
If the patient feels safe enough to inquire about the non-congruent message just sent by you, you have the opportunity to strengthen your relationship even further. Additionally, patients who experience your congruence are far more likely to cooperate, to adhere to plans and to give you as much information and help as they can.

**REVIEW**

Let’s start by assessing the rapport between doctor and patient in the next short video clip.

**Example 1:**

Click on the picture on the left and check out the first 15 seconds of a short video. Are patient and clinician in rapport? What clues do you find convincing?

**Discussion:**

Their smiles match. Their voice tones match. Their postures demonstrate equally relaxed body tension and ease of motion. The desk is not a barrier. Their eye contact suggests engagement.

**Example 2**

*Watch the complete movie now. This pair was in such good rapport just moments ago. What happened?*

**Discussion:**

This clinician is clear about her concern for this patient because of the family history of breast cancer. However, she has not effectively conveyed her concern in any way that will motivate the patient to obtain the mammogram. The clinician’s break in eye contact with the patient as she attends to the paperwork causes the clinician to miss the initial and dramatic turning away by the patient. Then, as the clinician delivers the paperwork to the patient, she does not react to the facial and postural cues of disengagement that signal the patient’s distress. The clinician fails to hear the patient’s change in paralanguage – the “oh sure” which is the patient’s explicit “yes”/agreement, but her voice tone speaks a louder implicit “no/disagreement.”

**Example 3**
This scenario unfolds the same way, until the clinician responds to the patient’s head hanging and sudden quiet with a verbal inquiry. Which nonverbal signals encourage the patient to disclose the source of her conflict?

**Discussion:**
After initial verbal inquiry, the clinician continues to lean forward, relaxes her extended hand and arm, keeps eye contact, and opens space with her relaxed silence.

How are these signals congruent with the clinician’s verbal responses? Her empathic verbal response directed towards the patient’s distress confirms the above-mentioned nonverbal signals.

What outcomes might differ between the two visits? We do not know the outcomes of the two visits, but we suggest that the patient is more likely to obtain the mammogram in the second instance, that the time spent in discussion is likely not more than an additional minute or two, and that both patient and clinician will likely be more satisfied with the second encounter. Higher satisfaction at resolving or simply addressing this patient’s conflict in the moment may have important positive long-term consequences.

**CONCLUSION**

We’ve covered a number of nonverbal skills. All of them can enhance the doctor-patient relationship, and their neglect can do serious harm to the relationship.

The key to working with these nonverbal communication skills is to practice, and to do so by breaking them down into small pieces.

For example, you can decide to specifically monitor facial expressions in the first two or three patients you see in the office on a given day. Then you can switch to voice tones on another day. At still another time, you might choose to pay particular attention to qualities of the space in your medical “encounters.” While you are out and about – say at a restaurant – notice who is in rapport and who is not. Over time you’ll become much more adept at reading all four categories of nonverbal communication in yourself and in others. We predict this will make for more congruent and rewarding exchanges with your patients.

**ACKNOWLEDGEMENTS**

The nonverbal communication model used in this module was developed by Cecile Carson, M.D. in 1987 through a grant from the National Fund for Medical Education.

The title for this module was first conceived by Doug Drossman, M.D. during a group project session of the American Academy on Clinician and Patient (now AACH) National Course on Medical Interviewing in Ontario, Canada, June 1991.
BEHAVIOR CHECKLIST

1. identify nonverbal behavior categories by observing patterns of kinesics, proxemics, paralanguage and autonomic responses:
   - "safe" - wide range of voice quality, reduced body tension, and diminished physical barriers
   - "not-safe" demonstrating "flight" - diminished and/or broken voice, crossed arms/legs, looking away, paler facial color, and heightened body tension
   - "not-safe" demonstrating "fight" - increased voice volume, engaged body position, facial flushing, and heightened body tension
   - "not-safe" demonstrating "conservation-withdrawal" - diminished or absent verbal output, looking down or away and slack body without facial tension – perhaps slumped toward the floor

2. develop nonverbal rapport using...
   - "matching" cues
   - "leading" patients

3. address mixed messages, using...
   - verbal reflection of the mixed message
   - normalization (legitimization)

4. shape the space, adjusting...
   - vertical distance
   - horizontal distance
   - angles of facing
   - reduction of physical barriers

LITERATURE REFERENCES


10. Personal communication, Dr. J Shorey and Dr. T Li, working with medical residents of Chinese descent who have shared their cultural reflections on this subject.


---

**Welcome to DocCom Module 15:**

**Understanding Difference and Diversity in the Medical Encounter: Communication Across Cultures**

by Calvin Chou M.D. Ph.D., Darryl Woods, M.D., Tonya Fancher, M.D., Ellen Pearlman M.D., Cathy Risdon M.D.

DocCom Module #15

“Cultural Issues in the Interview”

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:
Rationale
Calvin Chou, MD, PhD

The Patient's View

The Doctor's View
Calvin Chou, MD, PhD

Questions for Reflection:

1. How do you define culture?
2. What are the cultures with which you identify?
3. Reminisce about your cultural heritage: what values do you particularly like or dislike?
4. Recall how you felt when you experienced being different - perhaps in education, “social
standing, status or position” race, color, or ethnicity.

5. What feelings have you had when you experienced a sense of integration or effectiveness (or lack of these characteristics) in relation to other groups?

6. Recall a time when you felt culturally inappropriate. What happened? How did this experience influence you or change the way you now approach patients?

7. What difficulties have you noticed in interacting with patients whose backgrounds differ from your own?

---

**Key Principles:**

1. Not only is it impossible to know how aspects of every culture might influence an encounter, but also knowledge about a cultural group’s approach to illness cannot replace patient-centered communication.

2. The ability to consistently demonstrate curiosity and respect will assist in eliciting patients’ social context and their explanatory model of illness - and patients seldom volunteer this information.

3. Demonstration of empathic attention both to patients’ reactions and to your own frustration with patients who hold views contrary to your own views improves communication and care.

4. Diagnostic or treatment plans that patients will adhere to integrate their cultural beliefs with your standard-of-care biomedical approach.

5. You cannot significantly improve your effectiveness in cross-cultural interactions unless you maintain a keen awareness of your own cultural beliefs and influences.

---

**Learning goals:**

*At the conclusion of this module, you will be able to:*

- Describe how cultural differences affect patient-clinician relationships.
- Demonstrate skills of curiosity, empathy, and respect in cross-cultural encounters.
- Demonstrate skills of “empathic, curious confrontation” and “respectful explanation” in management of uncomfortable cross-cultural encounters.
- Reflect on your own cultural influences and explore how they affect medical interviewing.

---

**INTRODUCTION**
We invite you to envision difference and diversity as resources for improving patient care. We delineate skills that can bridge differences and lower the anxiety that accompanies straying outside your cultural “comfort zone”

The introduction section of this module is outlined as follows:

- **Illustrative Case: Mr. Ware**
  How can you bridge some of the gap between the culture of medicine and Mr. Ware’s concerns?

- **Difference**
  Differences between you and your patients test your ability to provide the highest quality and state-of-the-art medical care.

- **Communication flexibility**
  In order to co-create successful relationships and serve patients by providing the best care possible, you will learn new skills, and use them flexibly.

- **Culture**
  Characteristics ascribed to a cultural group (for example, gay men, clinicians, Catholics, people from China, or people with diabetes) typically correlate poorly with your experience of any individual group member.

- **Culture of medicine**
  Becoming an effective clinician for people who do not “live in the culture of medicine” requires that you forge a set of “bridging” skills that we explore below

- **Three key skills**
  Effective cross-cultural communication is built on the cornerstone skills of curiosity, empathy and respect.

- **Quiz Questions**

---

**Mr. Ware**

Mr. Ware’s concerns may be quite different from your medical ones.

You are seeing Cornelious Ware, a 67 year-old retired postal worker of African-American heritage. At his initial visit he disclosed a weight loss of 15 pounds over several months. He reported increased difficulty swallowing solids, finding that he has to chew his food past the point of its being flavorful in order to avoid an uncomfortable “sticking” in his throat. He had no pain and could swallow liquids fairly well. So he has avoided full meals, preferring instead to drink juices and smoothies. You suspected an obstructive esophageal lesion, and referred him to a GI specialist for endoscopy.

Today, he has lost 5 more pounds, without change in his other vital signs, and has no new symptoms. You do not find a note from GI in his chart. You ask him what the GI specialist advised. He says, “I didn’t go.”

---

**Culture and the culture of medicine**
Characteristics ascribed to a cultural group (for example, gay men, clinicians, Catholics, people from China, or people with diabetes) may correlate poorly or not at all with your experience of any individual member of that group. Becoming an effective clinician for groups of people who are significantly different from yourself requires that you forge an additional set of bridging skills, skills that we present and explore in this module.

Culture can be defined as an integrated pattern of learned beliefs and behaviors shared among members of a group. Shared elements include thoughts, styles of communicating, ways of interacting, views of roles and relationships, values, practices, and customs. Culture is part of everyone and includes individual influences such as age, socioeconomic status, religion, gender, sexual orientation, occupation, disability, geographic origin, and educational level, among others. Culture is a helpful construct for understanding the sum total of our experienced past and anticipated future as it relates to our affiliation with others.

Since no two people share the exact same set of experiences, beliefs, and attitudes, every encounter can be thought of as a cross-cultural experience. Additionally, remember that characteristics that we ascribe to a cultural group and what happens in an encounter with any one group member seldom correlate well; our assumptions about the larger group often do not fit the individual case.

In addition to the numerous cultural forces that shape each of us, every clinician has undergone acculturation to the professional lifestyle and exposure to the underlying scientific principles of medicine that few patients have experienced. Finding a bridge that can join medical culture to that of patients who live outside it requires attention to both the difficulty and opportunity of building those bridges.

Many instances of conflict between patient and clinician stem from differences in the way that patients experience their illness (see “Explanatory Models page,” below) and the clinician’s understanding of those symptoms as a diagnosis of disease (the biomedical model). Because of the inherent power differential in the patient-clinician relationship, it is incumbent upon clinicians to use a patient-oriented and illness-centered approach to translate the principles of evidence-based, standard-of-care medicine into terms that patients understand, and to incorporate the patient’s traditional beliefs into the plan of care. Modules 5 and 9 also discuss these principles.

---

**Difference and flexibility**

*Difference* fosters apprehension, but also provides opportunity that can expand your ability to serve well, to improve medical outcomes and to connect with patients to co-create fulfilling relationships.

*Difference* brings both difficulty and opportunity. When we encounter difference in a relationship, it usually tests our habitual patterns of initiating and responding, and those patterns may not suffice when we attempt to connect with someone different from ourselves. Such calls to an unfamiliar way of being are opportunities to learn, unleash creative energy, and acquire new capacity for future encounters across differences. The encounters are difficult because they provoke anxiety and can threaten our sense of competence.

Looking more closely at relationship dynamics, we find that no behavior or set of behaviors taken in isolation by either person will lead to a desired outcome. Each relationship is a new co-creation, and for a successful outcome, both people need to attend to the emergent, unique conditions of experienced past and anticipated future that create the lived present. In clinical encounters across difference, the ethical duty of service requires that clinicians develop flexibility and fluency with communication strategies that enable creation of an effective environment of care.

Clinicians create effective environments through engaging in true dialogue: iterative listening and
responding to patients with whom we are co-creating caring relationships. With intention, any clinician can listen actively, treat patients with respect, and provide clear explanations that build satisfying relationships. Importantly, the feel-good advantages that everyone feels in such relationships are only one important result. Incontrovertible evidence shows that communication quality and flexibility affects health care outcomes. Research from many domains is presented in DocCom Module 1, and notably includes better blood pressure and diabetes control, successful health behavior change, improved patient and clinician satisfaction and diminished malpractice claims.

Three key strategies

Three key strategies help build strong and resilient relationships with individual patients who differ from you in some cultural aspect. These strategies, curiosity, empathy and respect form the cornerstone of effective cross-cultural communication.

Showing patients that you intend to understand their cultural background - namely, their preferences, affiliations and cultural concerns – helps build trust and enable better medical care. For example, evidence shows that training in cross-cultural communication increases clinician awareness of the significant health disparities faced by people in the minorities of sexual orientation and socioeconomic status. As a starting point you will find it useful to have some familiarity with some different cultural subgroups’ approaches of to health and illness. However, it would be an impossible goal to know how every aspect of every cultural group might influence an individual encounter. Furthermore, developing encyclopedic lists of cultural generalizations inclines us towards perpetuating stereotypes.

There is no one way to treat any racial, ethnic, or other subgroup, since great cultural diversity exists within each subgroup. Every individual represents a unique mélange that resists easy categorization. Families are composed of increasingly diverse mixtures of different cultures. Many sources of difference are invisible but may be critical to patients’ sense of who they are and how they wish to be known. As you communicate with any patient, having gained some specific knowledge of a particular subgroup, that knowledge must be balanced by knowing and using effective patient-centered and family-centered communication strategies, namely, curiosity, empathy and respect. These key strategies, each one built on learnable skills, will not only enhance your understanding of cross-cultural differences, but also build trusting relationships with individual patients. We discuss the strategies and the skills in the following pages.

Quiz Questions

Consider the answers, then click on the Feedback-link..

1) All encounters can be thought of as a cross-cultural experience.

A) True
B) False

Feedback

2) A patient’s illness is defined as

A) The natural history and pathophysiology of a patient’s particular diagnosis
B) A patient’s mental instability
C) Symptoms and beliefs about a patient’s affliction, taken in his/her personal and
3) Which three of the following constitute a useful approach to cross-cultural encounters?

A) Assumption  
B) Curiosity  
C) Diagnosis  
D) Empathy  
E) Judgment  
F) Respect

CURIOSITY

Skills of curiosity include the following:

- Eliciting patients’ **values** about health
- Corroborating your **preconceptions** about a particular culture’s approaches to health
- Developing an understanding of patients as **whole persons** in a social context
- Eliciting patients’ **explanatory model** of illness

In this section you’ll find the following:

- **Eliciting Core Values about Health**  
  Ask patients about prior experience with clinicians or medical care to learn their beliefs about the medical community.

- **"Special" VIDEO about Curiosity**

- **Corroborate Your Preconceptions about Cultural Approaches to Health**  
  ..by inviting your patients to share their knowledge and understanding with you

- **Developing an Understanding of the Whole Person**  
  Overall, showing interest in patients’ cultural background and trying to know them as whole persons will help your rapport-building process.

- **Eliciting Explanatory Models of Illness**  
  A patient’s “explanatory model of illness” encompasses the meaning that the patient attaches to the illness, its causes, fears or concerns about its course, and hopes for treatment.

- **Quiz Questions**

**Elicit values, attend to hot buttons**

When cultural differences are substantial, your ability to show caring and expertise to patients, and their ability to receive these gifts, is a complex process. Ask patients about prior experience with medical care.
You remember that Mr. Ware said he had not seen a doctor for years, and came to the office at the urging of his wife, who was alarmed at his decreased food intake. Today you ask him why he hadn’t seen a doctor for such a long time. He says that he still feels healthy, and that doctors probably wouldn’t be able to tell him anything useful.

Communication barriers frequently spring up because clinicians’ and patients’ assumptions and expectations differ so dramatically. People carry aspects of their cultural identity in different ways. Sometimes the first clues to a different cultural approach to health arise from unexpected reactions to or misunderstandings in one or more of the core cultural issues in Table 1.

Table 1: Core Cultural Issues (“Hot Buttons”)(9)

- Authority
- Physical contact
- Communication styles
- Gender and gender roles
- Sexuality – expression, orientation
- Family – roles, decision making
- Spirituality, religious expression
- Personal resources – financial, social
- Privacy, confidentiality, truth-telling
- Prior negative experiences with health care systems

These issues are cultural “hot buttons” heavily infused with meaning and significance, and usually difficult to discuss openly. Patients’ interactions with clinicians will be affected by their acculturated approach to communication style, prior experiences with health care systems, gender differences, expectations for confidentiality, and age differences. Remain open and flexible and remember that patients are in unfamiliar territory, doing their best to accept your care across these fundamental differences.

As you build relationships, ask patients to relate a story about prior encounters with clinicians or health care systems. You might ask, "What challenges have you had with doctors in the past?" If the patient has had no contact with Western health care systems, consider asking about how the patient thinks about health or illness (see “Elicit the explanatory model of illness,” below). Pay specific attention to themes of cultural hot buttons (Table 1) or conflicts that arise during this dialogue.

AnnotatedVideo (not shown in print-out text)

Check preconceptions about health beliefs

Invite patients to share their knowledge and understanding with you – an invitation honors patients’ expertise and autonomy, corroborates (or negates!) your preconceptions and refines the accuracy of information that helps you to optimize care.

You: I understand that religion is very important to many of my African-American patients. Is that true for you?
Mr. Ware: My wife is the devout one – I basically go along for the ride.
You: Sometimes people mistrust doctors because of racial issues, experimentation like at Tuskegee.
[He looks at you directly for the first time all visit.]
Mr. Ware: That never happened to me, doc, but you never know. Those white doctors – you really can’t trust them. They hurt my people. They’re not going to hurt me.
You: I give you a lot of credit for coming in today. I can’t imagine it was easy.
Mr. Ware: Mm hmm.
You: Nowadays we have protections that prevent any experimentation like that. Would you be open to hearing more about the test we’d like to do?

Having a familiarity with cultural approaches to health that are common in patient populations with whom you interact is helpful. For example, some communities believe that supernatural forces cause illness, so patients or families may pursue the services of specialized shamans or rites such as exorcism. Conversely, do not assume that your Native American patient believes that the very mention of illness will, in turn, cause that illness (a common belief among Native Americans). Cultural groups may have different experiences in different locales. Perspectives are heavily influenced by one’s predominant culture, but each family or social unit can diverge significantly from a given cultural norm. Therefore, rather than provide a necessarily incomplete and inaccurate taxonomy of all cultures here, we encourage you to refer to online or print resources to gain some generalized background information on specific ethnic and cultural groups that you encounter (12,13).

If you have a preconception about a particular cultural approach to health, share your ideas and check to see if they are accurate for that particular encounter. “I understand that for some Latinos, religion is a very important part of health and illness. Is that true for you? How (or how not)?”

Develop an understanding of the whole person

Overall, showing interest in patients’ social context and trying to know them as whole persons will help your rapport-building process.

Many aspects of social context significantly affect patients’ approach to illness even though the contextual element may have no relationship to medical science. For example, after you tell your patient that he has a myocardial infarction, he may choose to leave your emergency department against medical advice because he lives alone, with few social contacts, and feels pressured to make sure that his cat has enough food for his predicted sojourn in the hospital. Your immigrant patient who completed third grade before beginning work as a manual laborer may not understand medical vocabulary and may harbor beliefs about illness that you view as bizarre.

Table 2: Understanding whole persons: Social Context.

Ask about the factors listed below, and preface your inquiries with a framing statement, such as: "The kinds of care we provide and the way we talk to patients may be different here than in the country you came from. I want to provide you the best possible care, so it would help me if I understood more about your culture."

A. Control over environment (e.g., finances, education):

1. Is money a big problem in your life?
2. Are you ever short of food or clothing?
3. How do you keep track of appointments?
4. Are you more concerned about how your health affects you right now or how it might affect you in the future?

B. Changes in environment (migration):

1. Where are you from?
2. What made you decide to come to this country/city/town?
3. When did you come?
4. How have you found life here compared to life in your country/city/town?
5. What was medical care like there?

C. Social stressors and support network:

1. What is causing the most difficulty or stress in your life?
2. How do you manage this stress?
3. Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?
4. Are you involved in a religious or social group? Do you feel that God (or a higher power) provides a strong source of support in your life?

D. Literacy and language:

1. How confident are you about filling out medical forms by yourself?
2. Do you have trouble reading your medication bottles or appointment slips?
3. What language do you speak at home?
4. Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?

The components of context in Table 2 cannot be addressed fully in a single clinical encounter of average length. Optimally, you will discover more about these domains as your relationships develop perhaps over several visits in the outpatient setting, or during a hospitalization).

Elicit "explanatory models"

Your work across cultures cannot be effective unless you elicit patients’ explanatory models of illness. An “explanatory model” encompasses the meaning that patients attach to an illness, causes of the illness, concerns about its course, and hopes for treatment.

You: What do you think is causing your swallowing problem?
Mr. Ware: You said it might be a tightness or a cancer in my esophagus.
You: Well, what do you think it is?
Mr. Ware: My wife feeds me too much. I’m here just so I can get her off my back. Probably I’m getting too fat around my swallowing tube because she makes me eat so much.

Many patients respond clearly to questions about their explanatory model, while others answer with a story that seems tangential to the discussion. Clinicians who focus on the biomedical model often find such stories frustrating, but close attention to the subtext usually provides insight into the explanatory model.

All cultures embrace many beliefs about the life issues of health and illness. Individual patients may hold all, some, or none of the beliefs typically associated with their identified culture, depending on their level of assimilation or integration. In addition to eliciting the explanatory model, determine how strongly the patient adheres to that model.

Some patients may be open to a more biomedical model that you offer, but others will hold a fervent belief system around illness and be closed to traditional biomedical thinking or treatments. Effective treatment of the latter group of patients (at least, in the biomedical world view) may take some creative collaboration as we discuss below and see Module 11).

Table 3: Questions that will help elicit patients’ explanatory model of illness (13)
What do you think has caused your problem?
What do you call it?
Why do you think it started when it did?
How does it affect your life?
How severe is it?
What worries you the most?
What kind of treatment do you think would work?

Questions that will help elicit patients’ health agenda:
- How can I be most helpful to you?
- What is most important for you?

Questions that will help elicit patients’ illness behavior:
- Have you seen anyone else about this problem besides a clinician?
- Have you used nonmedical remedies or treatments for your problems?
- Who advises you about your health?

Quiz Questions

Consider the answers, then click on the Feedback-link..

1) “I understand that some Puerto Ricans believe that certain spirits influence health and illness. Do you hold those beliefs?” This question is an example of:

   A) Checking your own preconceptions about cultural approaches to health
   B) Developing an understanding of the patient as a whole person
   C) Eliciting the patient’s core values about health
   D) Eliciting the patient’s explanatory model of illness

   Feedback

2) Consider a 41 year-old man with back pain. Which of the following questions does NOT elicit a dimension of a patient’s explanatory model of illness?

   A) Have you seen anyone else for your pain besides a clinician?
   B) How can I be most helpful to you?
   C) What do you think is causing your pain?
   D) Where is the pain located?
   E) Why do you think your pain started when it did?

   Feedback

EMPATHY

Attend to the verbal and non-verbal signals of connection and relationship from your patients, and learn from them. Your non-verbal signals of empathy are usually more helpful than your words.
**You:** It must be frustrating for you to have your wife tell you to eat more, and to feel forced to come here. I imagine you might feel you’re doing a favor for her.

**Mr. Ware:** I AM doing a favor for her.

**You:** I want you to know that I am not in cahoots with her – we’re here first and foremost for you and your health.

**Mr. Ware:** OK.

**You:** And I’d really like to thank you, truly, deeply, for telling me as much as you have, and for being honest about it. I imagine it’s been difficult for you.

[Mr. Ware’s expression seems to soften just a bit, though he remains silent.]

The modules on "Therapeutic Aspects of Medical Encounters" (Module 3), "Building Relationship" (Module 6), and "Understanding the Patient’s Perspective" (Module 9) emphasize the fundamental importance of using empathy in all health care encounters, whether you are speaking with someone of your own culture or not. Watching and listening for empathic signals from patients is probably the most useful method for learning appropriate expressions of empathy for a person from a different culture. You can check your impressions with the patient, and you can ask other people familiar with the culture who can act as cultural consultants or “translators” for you.

Among the difficulties you will encounter in communicating empathy across cultures are the following:

- Because clinicians are fully steeped in medical culture’s emphasis on science and technology, patient’s responses may be frustrating;
- A patient’s explanatory model may add confusing elements to conversations;
- Verbal statements of empathy may not build rapport with patients who cannot express their plight because of a language barrier, aphasia, or other tightly-held cultural beliefs.

Nonverbal empathic expressions such as voice tone and pace, smiling and eye contact are seldom fraught with cross-cultural confusion and are generally more helpful than verbal ones. See Module 14, "It goes without saying".

---

**RESPECT**

Show respect by acknowledging patients’ explanatory models when you offer biomedical plans for diagnosis or treatment.

Enlist the patient as a partner and collaborator in establishing plans for diagnostic studies or treatment interventions. To maximize the chances that patients follow up on plans, use the “ask – tell – ask” strategy outlined in Module 10 as you explore next steps and reach agreement on them. When you undertake planning across differences and diverse cultures, build trust by showing respect for patients’ culture and ideas. Successful outcomes depend on your covering some specific issues, such as those that we list below, and that we demonstrate in a sample dialog with Mr. Ware and the following video.

- Be aware of assumptions or preconceptions you probably carry, either because of your immersion in the biomedical culture or other aspects of your own cultural background.
- *(Ask)*: Summarize the patient’s explanatory model, and determine how strongly the patient believes in it.
- *(Tell)*: Offer the biomedical model as briefly as possible, avoiding jargon. Weave it together with the patient’s explanatory model as creatively as you possibly can. This very “This kind of “merging” of explanatory models usually involves discovering a creative combination of facts and conjecture. You may choose to reveal your own preconceptions, or to offer a suggestion as to how to proceed.
• **(Ask):** Ask the patient whether the new (modified) model makes sense, and elicit further questions and potential conflicts.
• **(Tell) (Ask) (Tell):** Continue to summarize, elicit understanding, and clarify.

Reach Agreement on the best compromise possible, which will depend on the trust in your relationship, the creativity of your weaving a tapestry that integrates the medical model with patients’ explanatory models, and how stringently patients carry their explanatory models.

**You:** Mr. Ware, sounds like you’re still having problems swallowing, and I can see that you’re still losing some weight.

**Mr. Ware:** Everyone tells me I look better.

**You:** Yes, but am I correct that you used to enjoy eating but don’t any more? You said you thought it might be getting fat around your esophagus?

**Mr. Ware:** Yeah, I think so.

**You:** Like you said, I think there might be something there. I don’t know about fat. Like I said last time, there might be a narrowing in your esophagus. It could be many things, and one of those things could be cancer.

**Mr. Ware:** Well, doc, what do you say we do about it?

**You:** I’d like for you to be able to enjoy eating again. I’d like for you to stop losing weight so rapidly. Would you like those two things?

**Mr. Ware:** Yeah, probably.

**You:** Ideally, I’d ask the GI doctor to take a look with a scope and a camera. But it seems like you might be worried that they’ll experiment on you?

**Mr. Ware:** You just can’t trust them to do what’s right for you.

**You:** If I could, I would refer you to a black or Asian GI specialist. Maybe I could see if there is one who could do your scope test.

**Mr. Ware:** Keep talking.

**You:** There is one GI doctor who I really trust. He is white, but he is one of the most trustworthy people I know.

**Mr. Ware:** Maybe I should talk to him first to figure out for myself.

**You:** That sounds like a good next step.

---

**Decisions: Central Themes**

When clinicians and patients face important decisions, certain central themes, “hot button” issues such as family and authority or thoughts about body organs and functions, and non-verbal cues come to the fore.

**The role of family and authority in decision-making**
The role of family and authority are fundamental cultural themes, anda key “hot buttons” among those already mentioned (Table 1). Especially in difficult situations, patients’ families’ attitudes to clinician advice influence medical decision-making. In addition, you will need to discover the cultural proscriptions around whether to tell patients their diagnosis, which family members to inform and how and when to disclose facts. Trust is of critical importance in people whose cultural background includes suspicions of Western medicine. Lack of trust may stem from patients’ or families’ strong faith in their own healing traditions, and personal, historical, or perceived experience with inappropriate or withheld medical care.

**Importance of language and ideas about body organs**
Different cultures express illness through body parts. For example, in Chinese, there is no verbal expression for “depression”; the closest description translates to “heavy heart,” which in literally translated, culturally insensitive encounters can lead to expensive and unnecessary work-ups for
coronary artery disease.

**Nonverbal communication** Physical contact is another central cultural theme; a patient may construe touch as an unacceptable breach of personal space, no matter how routine or innocently intended you perceive it to be. Physical presence, tone of voice, and gestures send powerful messages. The United States (except for some Southern regions) and Canada are relatively “low-context” cultures in which information is clearly delineated. In contrast, “high-context” cultures, such as Japan and Colombia, generally place higher value in social behaviors, ambiguity, and politeness, so that listeners infer messages without direct delineation, and nonverbal signs are of paramount importance (19).

In addition, some gestures that are acceptable in your culture may be insults in others. For example, the gesture used in the United States to show agreement or “OK” (thumb and forefinger formed in a circle, with the remaining fingers fanned outward) represents an unprintable insult in some southern European cultures. It is impossible to catalog all the world’s gestures here. We resign ourselves to the fact that we will occasionally make a cultural faux pas. Learning from these mistakes in a dignified and respectful manner without too much self-flagellation serves our patients (and us) most fruitfully.

**Table 1 : Core Cultural Issues (“Hot Buttons”)**(9)

- Authority
- Physical contact
- Communication styles
- Gender and gender roles
- Sexuality – expression, orientation
- Family – roles, decision making
- Spirituality, religious expression
- Personal resources – financial, social
- Privacy, confidentiality, truth-telling
- Prior negative experiences with the health care system

**PERSONAL AWARENESS IN CROSS-CULTURAL ENCOUNTERS**

In this section you'll find the following:

- **Discerning Your Own Hot Buttons with Mr. Ware**
  Enhancing your skill with cross-cultural communications depends on your continuing efforts to identify your cultural origins and explore and discern the ways that your cultural hot buttons affect your interactions with people different from yourself.

- **Review your non verbal signals**
  Videotaping and reviewing a cross-cultural interview increases your awareness of the effects of your nonverbal communications

- **Continue Exploring and Developing Your Awareness of Cultural Differences**
  Personal awareness does not have a discrete end-point, but is an ongoing process, particularly relevant to your effectiveness in communicating and building relationships across differences.

- **Check your Personal Awareness: a Cross-cultural Encounter**
Discern your own hot buttons

Unless you make a concerted effort to discern how your cultural hot buttons affect your interactions with people different from yourself, you cannot enhance your skill with cross-cultural communications.

As you reflect on Mr. Ware’s difficulty in interacting with the health care system, you are struck by an internal conflict. You wish to respect for Mr. Ware’s wishes, you know that a paternalistic approach would be ineffective, and the standard of care is to pursue upper endoscopy. You see that your inner conflict is a cross-cultural one – between older and younger, between his conception of his illness and your acculturation into medicine, and possibly other cultural factors such as differences in dealing with authority or power. You see that your inner struggle directly correlates to the developing conflict in your relationship. You realize that to resolve this conflict and provide the best care for Mr. Ware; your paramount consideration is to foster a sense of honesty and trust – by modeling honesty and trustworthiness.

You: Mr. Ware, I am being as honest as I can humanly be. I know I can’t force you to do anything you don’t want, and I respect that. At the same time, as your doctor, I’m feeling anxious to find out what is causing your symptoms, so we can get on with what to do next. As I mentioned, I have complete trust in the doctor I’m referring you to.

Mr. Ware: You seem like you mean it.

You [laughing]: I absolutely do!

Mr. Ware: All right. I promise I’ll go and talk to the GI guy. But if I can’t trust him, I need you to find me someone I can trust.

You: I promise to help work on that with you.

Review your non verbal signals

Videotaping and reviewing a cross-cultural interview increases your awareness of the effects of your nonverbal communications.

An additional effective method to develop personal awareness is to videotape a cross-cultural encounter, after obtaining the patient's consent. Review this videotape with a preceptor and colleagues. Not only do you increase your understanding of the non-verbal cues you send, particularly to a patient who does not have complete command over the language you use, but you also augment your knowledge of your verbal communication patterns.

Expand awareness of difference

Effectiveness in communicating and building relationships across differences does not have a discrete endpoint.

When you interact with patients whose differences from you are always multiple, those differences frequently contribute to confusion. The more deeply you understand your own cultural influences, biases, and approaches, the easier it will be to note differences in others’. We hope you will value being interested and appreciative of your patients’ cultural identities and value approaching other
cultures with fewer preconceptions. Review the “Reflection Questions” listed at the beginning of this module as one way to explore and appreciate influential aspects of your own professional and cultural identity.

Then revisit the Questions, particularly after challenging experiences, and continue to clarify how your own cultural heritage influences your clinical role. Share your reflections with other health care providers in order to enhance your understanding. We predict that if you apply the techniques of curiosity, empathy, and respect in safe collegial environments, the experience you gain there will assist you during difficult patient interactions. Note that study of DocCom Modules 2 and 4 will enhance your ability to explore personal issues relevant to your professional development.

---

**Check your personal awareness: a cross-cultural encounter**

A quiz, by Tonya Fancher, MD – U California, Davis; with Marilyn Mochel, Palee Moua – both from Healthy House, Merced

1. You are seeing a 60 y.o. Hmong woman for an initial visit to your practice. She does not speak English, and her grandson accompanies her, telling you that his grandmother has headaches and difficulty with sleep. After you establish that the headaches and sleep difficulty are the only issues for today, what is the recommended next step?

A) Ask, "Please give me a little more information about your headaches; like what brings them on, how long do they last, does anything make them better?"
B) Use your standardized approach for all Southeast Asian patients to develop a treatment plan
C) Ask, "Do your headaches make it difficult to do some things you would normally like to do?"
D) Ask, "What pain medications have you tried to help your headaches?"
E) Look for a staff member who might understand Hmong

**Feedback**

If the option is feasible, ask the patient if she would prefer a female or male interpreter.

2. When the interpreter arrives, you learn that the patient fled to Thailand after her husband and 3 oldest children were killed in the Vietnam war. She lived in a refugee camp and raised 3 young children alone, then emigrated to the US. She now lives with her oldest daughter and her 4 children. The patient tells you that the headaches have been going on for years, and states through the interpreter that she has a "broken liver."

Which of the following is the most appropriate next step:
A) Ask about GI symptoms like nausea, vomiting, diarrhea, bloody or black stools, jaundice, lethargy and so on.
B) Ask for help understanding what the expression “broken liver” means.
C) Ask whether she is using non-traditional healers and medications.
D) Ask whether she has been tested for tuberculosis.
E) Ask whether she drinks any alcoholic beverages.

**Feedback**

The interpreter explains that “broken liver” often reflects stress, and may be an indicator of more depressive symptoms. Following this lead, you learn from the patient that in addition to difficulty sleeping, she has a poor appetite and has considered taking her own life, although she denies active suicidal ideation. After discussion with her, you agree that a medication (a low dose anti-depressant) would be a good next step, and you refer her to a mental health agency with
expertise in Southeast Asian mental health.

In counseling her about the treatment plan, which of the following would NOT be an appropriate statement or action?
A) Tell her you will see her again in 6 weeks.
B) Tell her the expected side effects and time to resolution of symptoms.
C) Tell her that you and the agency counselor will work jointly to help alleviate her symptoms.
D) Tell her that you would like her to bring in an adult family member or friend who can help her with the medication.
E) Make empathic statements that show you understand her distress about difficulty with sleeping and poor life functioning.

Feedback

PREJUDICE

When patients, families, or colleagues express (knowingly or unknowingly) a cultural epithet or make a prejudicial or discriminatory remark, you can develop response options along the continuum of curiosity, empathy and respect.

When asking Mr. Ware background questions about his health-related behaviors, you ask, "Are you sexually active with men, women, or both?" He gives you an incredulous look and says, "Of course, women. Who do those people think they are, anyway?"

All clinicians find that answering with respect for both oneself and a valued "other" person in the face of a discriminatory remark is one of the hardest interview moments we ever encounter. One of the most powerful ways to build trust and relationship is to bridge this gap in a manner that values preservation of everyone’s dignity. We offer below potential response examples, more as guides rather than as specific prescriptions. Every situation is unique, and there are no simple "correct" answers so we offer potential advantages and risks with each aspect of the continuum of curiosity, empathy and respect.

Responses: Prejudice

Check out the video on the left

Which of the following strategies might you use to respond?

Curiosity

"I'd like to hear more about your attitudes towards 'those people.'” or,
"What do you mean by 'those people'?“

Possible advantages: can be easily used as a reflexive response; can make a patient feel
heard; can elicit a story or explanatory model that might make you understand why the patient holds that opinion; can be useful in situations where a patient launches a subtle epithet (a mere knowing glance, or something like “well, you and I know about people like that”).

**Possible risks:** you may encourage additional remarks that could make you more uncomfortable.

**Empathic response**

"Sounds like you have real misgivings about gay and lesbian people” or, “Sounds like ‘those people’ trouble you."

**Possible advantages:** reflecting the patient’s statement is easily done; this “simple” response shows that you heard the patient; and may elicit a story or explanatory model that can help you understand why the patient holds that opinion.

**Possible risks:** and empathic reflection may encourage further remarks that could make you more uncomfortable.

**Empathic, curious confrontation**

"Your position puts me in a bit of a bind, since I work with many gay colleagues. What do you feel that does to our work together?"

**Possible advantages:** establishes a sense of relationship and non-abandonment; offers self-disclosure and an opportunity for truth-telling for you; offers the patient an opportunity for explanation.

**Possible risks:** self-disclosure can feel threatening depending on your own cultural background; may come across to the patient as a power play

**Respectful explanation**

"Since many of my colleagues are gay, and since we are doing the best we can for your health, I would find it most helpful if you would keep those opinions to yourself, and I will do the same.” or, "I’m sorry, I don’t share your views, but I would like to reinforce the importance of our work together.” or, "I see lots of different people who do lots of different things, and for me, I’ve found that I can’t make any assumptions.”

**Possible advantages:** offers self-disclosure and an opportunity for truth-telling for you; establishes a firm mutual ground rule in agreeing to disagree

**Possible risks:** can come across as condescending or as a power play; may miss hearing a story that might make you understand why the patient holds that opinion

**Silence / Empathic Redirection**

“Some might find what you said pretty inflammatory. Let’s move on.” or, “[clinician raises eyebrows]”

**Possible advantages:** very useful if you are about to lose your temper or might say something you may regret later

**Possible risks:** you may miss hearing a story that could help you understand why the patient holds that opinion; a patient may interpret silence as agreement with the attitude or comment
No approach is risk-free. Your reaction in any given situation depends on numerous variables, including your prior relationship with the person and your state of mind at the moment. Having many tools grants you the flexibility in responding.

**Trigger Videos:** Click the trigger video below left - and then any of the eight recorded possible reactions by clicking a number in the carousel - how would you react?

- You should probably avoid using words such as “inappropriate” or “offensive” when responding, and at least hesitate to use them in your initial response. These words reveal more about your cultural orientation and your emotional state, and tend to underscore your position of power in patient-clinician relationships.

- Your professional duty is to combine standard-of-care medicine with a patient-centered approach. You may choose to challenge a patient’s underlying cultural assumptions, and occasionally this challenge may enhance your relationship. However, you must balance the benefits of sharing your own agenda and bringing such a disagreement to consciousness against the potential lessening of rapport, poorer adherence to medical plans, or underscoring of the power dynamics in your relationships.

- As you strive to expand the range of relationship situations in which you can provide service, taking the time to reflect and talking about these situations with colleagues or people with whom you feel allied and on whose personal support you can depend is always helpful.

---

**Behavior skills checklist**

1. Show curiosity about the patient’s cultural background.

2. Encourage the patients to tell a story about prior experiences with medical culture or illness.

3. Elicit information about hot button issues such as family roles, religion and truth telling, among others.

4. Ask about control over environment patients environment and social context, (e.g., for example, their finances, priorities), changes in environment (e.g., migration), support networks, and social stressors, and language.

5. Respond with empathy and respect as patients describe experiences with the culture of medicine, their hot button issues, or their social context.
6. Share your preconceptions about the patient’s cultural group’s approach to health and illness, and ask the patient if the ideas are accurate.

7. Elicit about patients’ explanatory model of illness and determine how strongly they believe in it.

8. When working with a patient on a therapeutic plan use a collaborative “ask-tell-ask” approach.

9. When establishing diagnostic or treatment plans, incorporate the patient’s explanatory model as creatively as possible.

10. In difficult, uncertain or potentially prejudicial cross-cultural situations, respond with empathic and curious confrontation, respectful explanation, or silence.

11. Demonstrate an interest in increasing your awareness of difference, discerning your hot buttons and adjusting your responses to prejudicial situations.

Literature References


11. Institute of Medicine. “Unequal Treatment: Confronting racial and ethnic disparities in health


Welcome to DocCom Module 16:
Promoting Adherence and Health Behavior Change

by Carol Chou MD, Michael B. Goldstein, MD, F. Daniel Duffy, MD, Rob Shochet, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details
Facilitator Guide of this module for DocCom Residency Doctoring Curriculum

Credits:

Authors: Carol Chou, MD, F. Daniel Duffy, MD, Michael B. Goldstein, MD, Rob Shochet, MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient: Heidi Fergusson, Dan Leader
Clinicians on camera: F. Daniel Duffy, MD, (microskill videos) and Michael B. Goldstein, MD (relevance).

Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.1 - 1/31/2013 Revision by authors
3.0 - 1/12/2012 enhanced with HTML5 code and MP4 videos
2.0 - 8/3/2009 Update toocCom Version 4.0
1.0 - 7/15/2005

Video is loading...

Rationale
Michael B. Goldstein, MD

Video is loading...

The Patient's View

Video is loading...

The Doctor's View
Rob Shochet, MD

Questions for Reflection:

1. How do you feel when people you care about engage in unhealthy or risky behaviors?
2. What difficulties prevent patients from taking their pills, using condoms, or stopping drinking?

3. Does motivation for behavior change originate within a person or is it brought to bear from outside a person?

4. On a scale of 0-10, how convinced are you that it is important for clinicians to learn specific skills for helping patients adhere to treatment regimens—or change an unhealthy or risky behavior?

5. How confident (0-10) are you that you will be able to use these specific skills when you are tired, multi-tasking, and frustrated about what patients actually do?

6. How difficult is it for you to respect patients’ autonomy to make a choice that you believe might be harmful to goals they have for themselves?

---

**Key Principles:**

1. Many patients seem unwilling or unable to adhere to recommendations or change an unhealthy or risky behavior.

2. Nonetheless, research shows that many patients successfully change behaviors in response to brief counseling interventions.

3. Clinicians who counsel effectively about behavior change use specific assessment and advising skills that research shows are of proven benefit.

---

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe the “5 A’s” model for helping patients change a behavior.
- Assess patients’ “stage” of change, and their conviction and confidence about changing.
- Explore and appreciate patients' attitudes, values, and feelings about behaviors and changes in behaviors.
- Respond empathically and collaboratively when patients voice ambivalence or reluctance about changing behavior, including risky behaviors.
- According to patients' readiness, collaborate and negotiate your recommendations and advice about adherence and other behavior changes.

---

**INTRODUCTION**
Extensive research produced robust evidence that the use of patient-centered and relationship-centered counseling skills enhances patients’ likelihood of successful change. We review the “5 A’s” - Assess, Agree, Advise, Assist, and Arrange - and describe specific skills to implement each “A.”

Patient education and counseling is a core function of all medical encounters and an essential component of quality medical care. (1-3, 69, 70). Indeed, clinician use of effective communication and counseling skills promotes treatment adherence and facilitates change in patients’ risky health behaviors, including smoking, problematic substance use or unsafe sexual practices. (1, 4-9)

Unfortunately, health behavior counseling rates fall well below the targets recommended in Healthy People 2010, the US Health and Human Services’ blueprint for preventive and behavioral health objectives for the nation.(9,10) Multiple patient and clinician barriers to effective intervention are shown in Table 1. Clinician skepticism about spending time on patient education and counseling derives in large measure from these barriers.(6,9)

<table>
<thead>
<tr>
<th>By Patients</th>
<th>By Clinicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not knowledgeable about risks</td>
<td>Not enough time in visit</td>
</tr>
<tr>
<td>Unaware of more acceptable options for change</td>
<td>Not trained in counseling</td>
</tr>
<tr>
<td>Lacks social support for change</td>
<td>Frustration with patients who seem not ready to change</td>
</tr>
<tr>
<td>Feels too stressed to change</td>
<td>Uncomfortable giving up control over goals and options for change</td>
</tr>
<tr>
<td>Lacks confidence from prior failures</td>
<td>Difficulty feeling comfortable with less than perfect plan</td>
</tr>
<tr>
<td>Lacks support and understanding</td>
<td>Difficulty appreciating patient perspectives</td>
</tr>
<tr>
<td>Feels ashamed or guilty about behavior and therefore responds defensively</td>
<td>Difficulty expressing empathy when patient responds defensively</td>
</tr>
</tbody>
</table>

Table 1: Barriers to Health Behavior Counseling

Despite these barriers, multiple studies show that clinicians who participate in specific training interventions do a better job of health behavior counseling (11-16). Moreover, interventions that use a team-based approach and combine clinician training with supportive prompts or other organizational interventions improve counseling effectiveness even further.(17-24, 69, 70).

THE 5 A's - A UNIFYING APPROACH

The “5 A’s” construct derives from decades of painstaking research studies across many disciplines. The 5 A’s remind clinicians how to effectively promote health behavior change in everyday encounters.

Over several decades, researchers studied behaviors that are detrimental to health, such as smoking, drug use, overeating, and not taking prescribed medicines, seeking methods to help people change. Several effective models emerged, including the Transtheoretical Model of Change [27], Social Cognitive Theory (28, 29), Self-Determination Theory (30, 31), and Motivational Interviewing.(32-34, 67) The 5 A’s framework - Assess, Advise, Agree, Assist, Arrange follow-up - incorporates elements of several models cited above and is consistent with their principles. Many skills that are required to carry out elements of the 5 A’s parallel or overlap skills that are demonstrated in DocCom Modules 5-12. Table 2 lists the 5 A’s.
Assess health behavior

Begin inquiry with open-ended questions about health behaviors. Follow up by using empathy skills that not only build trust, but also help patients to reveal their own biases, beliefs and feelings about those behaviors.

The first A, Assess, focuses on gathering information about health behaviors, beliefs about the behaviors, ideas about and experience with change, and facilitators and barriers to change. Assessment usually begins with open-ended questions about health behaviors. Assessment targets include: 1) adherence to treatment and medication recommendations; 2) tobacco use, risky drinking, sedentary behavior, diet, sexual practices; 3) self-management behaviors for chronic illness - namely, self-monitoring, symptom management, functions of daily living and following through with medical visits; and 4) patients’ ideas, beliefs and feelings about those behaviors and changing them, in order to tailor advice and assistance about change to patients’ readiness, motivation and needs.

The following dialogue demonstrates assessment of a patient’s adherence to plans for treatment of congestive heart failure.

**Doctor:** "Many people have difficulty following through with taking medications and doing all the other things that are necessary to manage their heart condition. What difficulties have you been having?"

**Patient:** "Well, to be honest, I have had a hard time remembering to take my medications when I am supposed to take them."

**D:** "It sounds like it has been pretty challenging for you."

**P:** "Yes, it has....Sometimes I just get tired of taking pills. It seems you add new ones all the time, and then you change them. Isn’t there a better way?"
D: "I can see that you are pretty frustrated. I appreciate how hard you have been working to manage your condition and take all of your medications. Let’s see whether we can something to organize a better regimen for you.”

The clinician begins the assessment with an open-ended question (after a brief preface), then follows with empathic statements. A legitimizing (also called normalizing or validating) statement is used ("Many people have difficulty......") and then a partnership statement. Use of these core skills builds rapport and increases the likelihood of adherence and other health behavior change outcomes.(8, 35)

---

**Assess readiness for change**

Elicit information to assess patients’ motivational readiness for undertaking change – evaluate their “stage of change.”

Extensive research demonstrates that eliciting patients’ reflections about their desire, ability, reasons or need for behavior change promotes subsequent health behavior change.(8, 9, 32) After gathering information on a targeted behavior and learning about the patient’s beliefs and feelings, complete the first “A” with an assessment of motivational readiness. (27, 36) Some research suggests that individuals who change a behavior progress through a series of “stages.” Indeed, clinicians find that the stages concept helps them more fully understand the difficulty of behavior change and the dilemmas their patients face. The stages are:

- **Precontemplation** - unaware of a problem or no intention to change in the foreseeable future
- **Contemplation** - ambivalent about changing with no commitment to change in the near future
- **Determination** - intends to take action within the next month or has made some recent changes in behavior
- **Action** - actively attempting to change
- **Maintenance** - has changed and needs to prevent slips and relapse
- **Relapse** - has changed for extended periods, but has returned to prior behavior

West(76) presents evidence to suggest that clinicians should avoid designating or labeling an individual patient as “in stage X.” Stage definitions are sometimes less certain than they seem, they may overlap, or a patient may manifest characteristics of several stages in a single conversation (2). Further, many patients harbor some aspect of motivational readiness of which they are not aware in the moment or which they cannot or do not articulate (77). Their clinicians may then miss an opportunity to fan or ignite that motivational spark.

Thinking only about “stage” may allow clinicians to avoid - consciously or unconsciously, see DocCom Modules 1,2,3 - the ambiguity of behavior change conversations and prematurely limit dialogue, especially if they deem patients to be in precontemplation. “After all,” they say to themselves, “this patient wishes to avoid the lumpiness, snail’s pace progress and frequent failures of trying to change behavior.”

As an aid to more fully appreciating the nature of the stages, Dr. Dan Duffy engages a patient in a series of short videos.
Video examples: When you click "stages of change" buttons above, the example shows what a patient might typically say in a particular stage.

Assess conviction and confidence

Assess patients’ sense of importance regarding changing a behavior - their conviction- as well as their perceived ability to successfully change - their confidence.

Understanding change as a "process" rather than an "event" assists clinicians in engaging patients' intrinsic sparks of motivation, no matter how dim.

Many clinicians who see unhealthy behaviors reflexively suggest an action-based strategy such as medication or referral to counseling, just as do patients' friends, spouses and parents. Because many patients are unconvinced, or lack confidence (they seem to be in an early "stage,") action suggestions often "fall on deaf ears," producing frustration, irritation or confusion for everyone. (37, 38)

Placing emphasis on patients' beliefs and perspectives about the importance of change, and confidence about success at change helps clinicians avoid not only the traps of "labeling," and "they aren't ready to talk," but also avoid the urge to recommend action strategies too soon.

Conviction assesses what patients believe about the importance of taking action, while confidence assesses what patients believe about their ability to change a behavior despite obstacles or barriers (sometimes called their "self-efficacy.") (33, 34) In addition to assessing which "stage" patients seem to be in, assessing patients' conviction and confidence helps ascertain motivational readiness, and helps the clinician to appropriately tailor the next interventions.

Many clinicians use a "ruler", a numerical rating scale shown below that assists in clarifying the extent of patients' overall "readiness," builds trust and usually encourages additional helpful dialogue.
Assessing Conviction

Use the rating scale to ask the patient: “On a scale of 0 to 10, how convinced are you that it is important to....

Not at all convinced 0 1 2 3 4 5 6 7 8 9 10 Totally convinced

Assessing Confidence

Use the rating scale to ask the patient: “On a scale of 0 to 10, how confident are you that you can.....

Not at all confident 0 1 2 3 4 5 6 7 8 9 10 Totally confident

**Figure 1**: Visual “ruler”

Frame questions as follows:

**Conviction** or importance --"On a scale of 0-10, how convinced are you that (behavior... like exercise or stopping drinking) is important?"

**Confidence** or self-efficacy --“Let's suppose for a moment that you were a 10, completely convinced that you should start exercising (or quit drinking;) on a 0-10 scale, how confident are you that you would be able to get a solid start on this in the coming 2-3 weeks?"

When conviction scales very low (e.g. 0-2), the patient is saying “My readiness to think about this issue is very low,” and her “stage” would be near **precontemplation**. As discussed, stage and readiness each describe aspects of the change process. With higher conviction but low to intermediate confidence, the patient is saying “I’m thinking about this, maybe I’m ready to act,” and the “stage” could be **contemplation** or **determination**. Patients with high conviction and intermediate to high confidence are typically saying, ”I’m on board, and ready to find out what action I can take next to stop (or start) this behavior,” and the “stage” would be **action**.

---

**Assess readiness to continue**

Be certain to ask permission to carry on. Continue to use “Build Relationship” empathy skills; specifically, express appreciation of patients’ past efforts. Every action, successful or not, is a “learning opportunity.”

The following example demonstrates how a clinician uses the ruler to assess the interest of a young woman in adopting the healthy behavior of using a birth control pill - or the healthy alternative of having her partner use condoms. The patient has asked for a “morning after pill”.

**Doctor:** “Have you considered asking your partner to use condoms when you have sex?”

**Patient:** “No, not really. He doesn’t like them.”

**D:** “So, it’s hard to ask him to use them.”

**P:** “Yeah, I don’t want to push him to do something he doesn’t want to do.”
D: "I see. Would it be ok if I asked you a few questions about your views toward condom use?"

P: "Yeah, I guess."

D: "Ok, on a scale of 0 to 10, how convinced are you that it is important to use condoms during sex?"

P: "Oh, I would say a 4."

D: "A 4....what led you to say 4 and not lower?"

P: "Well, I know they can keep me from getting pregnant....and I know they can help me to avoid an infection."

D: "That's right! I am glad you understand some of the benefits. Anything else that makes it a 4 and not lower?"

P: "Well, I certainly don't want to get AIDS."

D: "No one wants to get AIDS."

P: "My partner has been tested and he is fine.....but I guess you never know."

D: "Right again. What would it take to raise the importance of using condoms?"

P: "Well, maybe if I thought I could get him to use them."

D: "Hmmmm...so you need some help in convincing him of the value of using them."

P: "That's for sure!"

D: "I have some thoughts about how you might talk with him, and I also can provide you with some information on that topic from Planned Parenthood. Would you be interested in hearing them?"

P: "That would be good. Thanks!"

The interaction above demonstrates important characteristics of effective health behavior counseling; namely, respect for patients’ preferences and support of patient autonomy. In the dialogue the clinician seeks the patient’s permission to assess her beliefs and feelings, which the patient grants, even if hesitantly.

In the dialogue, the clinician goes on to use the conviction scale. Asking “why 4 and not lower” stimulated her to reflect, and subsequently express “change talk”. (See Appendix) Then, the clinician uses a follow-up question (“what would it take to ... conviction?”) to identify an important barrier to change, as well as discover a potential solution.

As this conversation illustrates, in addition to assessing beliefs about change that are seldom made explicit in medical interviews, engaging in this dialogue usually facilitates patients’ making additional statements about motivation, thoughts, ideas and beliefs, as well as about previous actions or steps they’ve heard about from friends, T.V. or the news. This is true even when patients protest that they do not like to use number scales.

One final point about this dialogue - asking why the number the patient chose is not LOWER than the number chosen encourages patients to voice any thoughts they have about change in POSITIVE terms, smoothing a transition to talking about recommendations.

These principles are highlighted in the brief summary of Motivational Interviewing in the Appendix, below. DocCom Module 10 discusses “Asking permission” in more detail, and Module 10
videos demonstrate this skill.

Relapse

When patients disclose relapse into a prior behavior pattern, assess their feelings about the relapse. Then, assess both past change strategies and conviction and confidence about future change. The data about feelings and readiness to learn from the relapse helps clinicians to respond with appropriate counseling strategies.

Patient: "I feel a bit ashamed to tell you this.....I went back to smoking last month."

Doctor: "You seem upset about it."

P:"Yes.....I had worked so hard to get off those darn cigarettes."

D:"Yes, you worked very hard. So, what happened?"

P:"Well, I had weaned myself off the patch about 2 months ago and I was doing fine. Then my boss made increased demands on my time. I had several new projects to complete and felt anxious about getting them done. One night, I was going through some drawers looking for some papers....and would you believe it, I came across an old pack of cigarettes. I thought I would just smoke one to get me through the night. Then, I smoked another, then another. I felt terrible"

D:"Terrible."

P:"Yes, like a failure."

D:"Failure is such a strong word"

P:"Well, I returned to smoking....I failed."

D:"Actually, you were free of cigarettes for almost 6 months. So, you successfully avoided smoking more than 3500 cigarettes before having that first cigarette. That sounds successful to me. In fact, many folks need to quit repeatedly before they learn what it takes to stay a non-smoker."

P:"I guess you are right. So, what do I do now?"

D:"Well, let me ask you a few questions, and then we'll think together."

P:"Sure."

D:"How convinced are you that it is important to quit again?"

P:"Oh, it is still a 10."

D:"Ok, you are still convinced about the importance of quitting. That's great. How confident are you that you can quit again, on that scale of 0 – 10?"

P:"Oh, I'd say a 5 or 6 right now."

D:"So, what makes it a 5 and not lower?"

P:"Well, the patch really helped me...it cut the craving way down."

D:"What else helped?"
**P:** "Well, I used those strategies to get ready, they helped too. And the online support group you suggested....that was wonderful."

**D:** "Sounds like you have a number of ideas about what can help you to quit again."

**Discussion:**

In the dialogue above, the clinician gracefully integrates “Build Relationship” skills of attentive listening and empathy (DocCom Module 6) with the assessment of conviction and confidence. The clinician “asks” directly about the patient’s experience with relapse, and this assessment leads the patient smoothly into a discussion of her willingness to try quitting again. The clinician’s assessment of her past successful quitting strategies brings to light ideas that they may jointly draw on to produce a specific plan (see Agree and Assist below).

---

**Advise**

After completing an assessment with “asks” that clarify facts, feelings and beliefs, begin to “tell” information and advice. Offer information in small chunks, and continually check with patients about their understanding and agreement.

Offering “advice” is the 5A’s element most familiar to clinicians. Controlled studies show that following an assessment with very brief advice - suggesting a specific behavior change - is an effective intervention for promoting change in health behaviors such as smoking cessation, or reduction in risky drinking. Refer to DocCom Modules 10 and 11 for “tell” strategies about giving advice. When more than a few moments are available for interaction, put advice into patients’ specific contexts so as to maximize effectiveness, as shown in the following example.

**Doctor:** “As your doctor, I have some information about how cutting down on smoking can favorably affect your health. Would you be interested in hearing about these?”

**Patient:** “OK, I suppose.”

**D:** “Stopping smoking will reduce the number and seriousness of your lung infections. Quitting should also allow us to reduce the amount of medication you have to take to control your asthma. What do you make of this?”

**P:** “I won’t have to take as much medication?”

**D:** “That’s correct ....and that should help to address some of your concerns about finances. Quitting smoking will allow you to save a bunch of money – at a pack a day you are spending quite a bit on cigarettes.”

**P:** “I could sure use that extra money.”

As noted previously, show respect for patients’ autonomy by “asking” permission before giving advice, especially when conviction is low. Once permission is granted share information using an “Ask, Tell, Ask” sequence. For example, before giving advice about monitoring blood sugars, you might ask, “What do you understand about the benefits of checking your blood sugars?” Always deliver information in small bits, and then assess what the patient heard and learned.

---

**Agree**

Tension always exists between small steps and “optimal” health behavior change. Collaborative agreement on an achievable step forward secures progress, in contrast to
persuading patients to accept “optimal” goals that they are unlikely to achieve.

Agreeing on a measurable and achievable goal for change makes evaluation of progress toward change feasible, and promotes small successes instead of big failures. Goal setting is a crucial determinant of successful behavior change outcomes (41,43,44), but agreement on goals for change is too often absent from patient encounters.(42)

Foster a collaborative process for identifying goals, one that includes eliciting and clarifying patients’ goals, articulating health-promoting clinical goals and finding common ground.(42,45,46) Demonstrate a collaborative stance by using partnership skills and exploring patients’ perspectives (DocCom Modules 6, 9) in a non-judgmental way. Time spent on seeking agreement on simple and realistic treatment goals is time well used, and increases the likelihood of successful change.

Help patients set realistic goals, and foster autonomy by supporting their choices. An achievable change goal, such as “take the diabetes pill twice daily” is more important than a bigger step that is likely to fail, such as “check sugar level 4 times a day and adjust eating and activity to optimize blood sugar levels.” The foremost goal of collaboration is to fully empower patients so that they can take on the hard work of behavior change. “Settling for less” than optimal behavior change from a health perspective may be difficult, but remembering that patients control their actions between visits may help you be patient during the change process. For example, goal options for ambivalent patients engaged in hazardous drinking might include simply monitoring drinking, or reviewing educational materials, or supporting their idea to go to an AA meeting with a friend, just to see what it is like.

---

**Quiz: diabetes management**

Quiz. Read the case and dialogue below and identify the skills Dr. W utilizes as she collaborates with Ms. D to establish an achievable weight loss goal.

Dr. W has cared for Ms. D for years, and after discovery of Type II diabetes many months ago, they are continuing to improve management. Ms. D has succeeded in taking oral hypoglycemic medication regularly, checking blood glucoses daily and monitoring her diet carefully but she is frustrated that despite these successes her hemoglobin A1C is still high. So far, she has not been able to lose weight or increase her physical activity.

Find “summary, legitimization, partnership, appreciation, seeking perspective, ask and tell” in the dialogue below.

**Doctor W:** “So, to summarize, it sounds like you have been checking your blood sugars very diligently, taking your medication every day and trying hard to follow the dietician’s recommendations. You are having a tough time fitting activity into your routine and you have been struggling to lose weight. Though your hemoglobin A1C is down from the last visit, it is still close to 8 and both you and I would like to see it get down to 7 or below.”

**Ms. D:** “That’s right. I am so frustrated about my weight. I think I need some more help to be successful. I want to avoid having to take more medication to get that number down.”

**Doctor W:** “Ok. I am hearing that your preference right now is to work on your weight. I can help you with that and we can hold off for now on recommending an increase in your medication.”

**Ms. D:** “Thanks. Do you have any recommendations about what else I could do?”
Doctor W: “Sure, though I would like to hear your ideas, too.”

Ms. D: "Well, I read recently that exercise is very important, but that you have to exercise for an hour a day to actually lose weight and keep it off. An hour a day just seems impossible for me."

Doctor W: “It’s great that you’re seeking out the latest information. Though an hour a day is linked to sustained weight loss, the hour of activity can be broken up into multiple bouts of activity over the course of a day. Also, shooting for an hour a day when you are just getting started is too difficult for most people.”

Ms. D: "You mean I can start out slow and work up to an hour a day?"

Doctor W: "Absolutely. It is usually best to set a more modest goal to start. What do you think is a realistic starting goal for you?"

Discussion:
In the above dialog, Doctor W asked Ms. D. about her preferences for a goal. They negotiated, and Doctor W said she was willing to hold further increases in Ms. D’s medications while agreeing on Ms. D’s choice to work on a weight management through increased physical activity. Once physical activity was chosen, Dr. W continued to help Ms. D. to choose a realistic and measurable short-term goal.

Assist

Help patients develop action strategies, and help them identify and overcome barriers to implementation. When the required actions are extensive, complex, or completely unfamiliar, bring in an expanded clinical team. Set new goals if confidence is too low.

After patients have chosen a goal, your role shifts to assisting in development of a specific, realistic plan to achieve it. Just as with setting goals, active problem-solving to make a coherent and feasible plan works best when patients identify a resource or strategy themselves.(32) Exploring past experience with change may help patients identify strategies that were previously successful, at least partially or temporarily. In addition, identifying what went wrong after a period of success may clarify strategies toward a more durable result.

If patients have high conviction but low confidence, focus on discovering strategies to enhance confidence or self-efficacy. Identifying and overcoming barriers to success is another important aspect of this process. Exploration of resources within the patients’ families, social network, and environment may uncover valuable supports. You may enlist an extended team member to teach specific coping and self-management skills, or strategize appropriate “baby steps”.(29,47) If you work in a multidisciplinary team, the burden of education, counseling and skills training may be shared among several clinicians. Alternatively, you may decide to refer patients to counseling professionals or services outside of your practice (e.g., telephone counseling programs, self-management programs) (See also the discussion of the Chronic Care Model below.)

Before you close a session, assess patients’ confidence to implement the plan. If patients’ confidence ratings are less than 7, they are less likely to succeed. If confidence is low, consider: 1) continuing to identify and resolve barriers until patients’ confidence is at least 7; or 2) identifying a more limited goal that patients believe they can achieve, with a confidence rating of at least 7.

Quiz: design effective plan

Quiz. Read the case and dialogue below and identify the skills Dr. W utilizes as she
collaborates with Ms. D to establish a **plan** that will achieve her weight loss goal.

We continue the previous case scenario to demonstrate some components of the “Assist” step. Dr. W. assists Ms. D. in exploring exercise strategies and resolving potential barriers to success so that she feels confident she can accomplish this first step.

Find “appreciation, reflection, partnership, rehearsal, seeking perspective, ask and tell” in the dialogue, as they collaborate on developing a plan.

**Ms. D:** "Well, I am not someone who likes to go to the gym. I enjoy walking, though."

**Dr. W.:** "Walking is an excellent choice. Any thoughts about where you would like to walk?"

**Ms. D.:** "Well, I could walk in my neighborhood before or after work, or I guess I could stop at the high school on the way home……I think I prefer walking in my neighborhood. We are new to the area and this might be a way to meet some neighbors."

**Dr. W.:** "Great idea...so walking in your neighborhood. I am filling out this Action Plan so we both have a record of what you are planning to do. Can you specify when you will walk?"

**Ms. D.:** "Hmmm. The best time for a walk will be after dinner. Maybe I can even get my husband to come with me."

**Dr. W.:** "Having company and support can help. How many minutes do you want to walk....to start?"

**Ms. D.:** "Let’s say 20 minutes."

**Dr. W.:** "How many days each week?"

**Ms. D.:** "I think I better just start with 3 days this coming week."

**Dr. W.:** "That sounds very achievable. Can you think of any down side or barriers to your plan?"

**Ms. D.:** "Well, my husband is in pretty good shape. He might want to walk too fast. I will have to ask him to be patient with me."

**Dr. W.:** "It is fine to start out at a leisurely pace. Eventually, to promote weight loss, you will want to move up to a moderate pace......a pace that produces a light sweat, but is slow enough so you can carry on a conversation. I can have Mary teach you to take your pulse too, if you are interested in getting more precise feedback about the level of activity that will help you to meet your goal of losing weight."

**Ms. D.:** "Maybe I can work on taking my pulse another time. Keeping track of my level of exertion seems fine to me."

**Dr. W.:** "That’s fine...any other barriers?"

**Ms. D.:** "No, I can’t think of any."

**Dr. W.:** "Ok, we have a plan. Would you like to review the plan with me?"

**Ms. D.:** "Sure....let’s see...I will walk for 20 minutes, 3 times a week, in my neighborhood after dinner, with my husband. I will start at a leisurely pace and gradually try to increase it. ’’

**Dr. W.:** "Excellent! So, how confident are you that you can implement your plan, on
that scale of 0 – 10, where 0 is not at all confident and 10 is extremely confident?"

Ms. D: "9. I could probably say 10, but I usually don’t give 10s."

Dr. W: "Fair enough. Here is your copy of the plan."

**Assist: low conviction or low confidence**

Pressing on toward plans for undertaking change with patients who are uncertain about their NEED to change or their ABILITY to do so annoys and sometimes even infuriates both clinicians and patients, and guarantees a “no change” outcome.

People need both strong conviction and at least a modicum of confidence before they will invest energy in learning how to change. For patients who reject the idea of change (e.g., conviction=0-1, *precontemplation*), return to the Assess, Advise and Agree steps. Evidence suggests that it may help to continue exploring patients’ experience, beliefs and feelings to better understand their low level of conviction. Experts call this “roll with resistance.” Asking about their rating, for example, “What makes it a 1 and not 0?” or even, “Zero...that’s as low as you can get...what would have to happen to make it a 1?” may provide an opportunity to appreciate or affirm their insight by saying “So, I see that you realize there are some potential benefits to change”. Your recommendation (“advice”) might be to -with permission- suggest that patients read information, talk with people who have changed, discuss the behavior with a partner or family member, or simply monitor their behavior so as to discuss their feelings and the effects with you at a following visit. If your patient agrees to one of these limited steps, you can then develop a specific plan to achieve the goal.

Many patients in general medical settings - data suggest that the percentage is about 60 - are thinking about change, but ambivalent (in *contemplation*). They have low (but not as low as 0-1) conviction OR low confidence. For these patients you may give clear advice-with permission- but refrain from prematurely suggesting action plans or trying to persuade them. Consider talking about their conviction score and then eliciting and discussing the pros and cons of change, or exploring the reasons they think they cannot succeed and then problem-solving with them.

In short, shift the focus from trying to *induce change* to trying to enhance conviction and confidence. To argue, to persuade or to “predict calamity” about changing something that patients either do not believe in or feel hopeless about is frustrating and fruitless. Letting go of the illusion of clinician “control” and broadening the perspective to elicit, explore and include the patient’s feelings, beliefs and concerns creates new opportunities for finding common ground. More information on these skills is in the Appendix, (“For advanced clinicians”), and in **DocCom Modules 24,25,29,30** (on smoking, alcohol and drugs, nutrition and exercise).

**Arrange follow up**

Arrange scheduled visits and arrange for patients to make appointments for consultants, education classes, mutual help groups, and so on.

The essential final component of the five “A’s” is arranging follow-up visits, calls, and other continuing clinical contact, such as education classes, counselor and consultant visits, or rehabilitation programs. When arranging follow-up contacts, be specific about dates and times, and help patients arrange the details for following through with appointments.

Adopt and maintain a long-term perspective when managing patients with chronic illness or addressing long-standing risky health behaviors. Evidence from the research literature on chronic
care management and health behavior change indicates that patients need multiple planned contacts to achieve the best outcomes. \((7,22,41,49,50)\) Follow-up is important even when patients are in precontemplation or contemplation and not ready undertake change. Brief advice, even during single contacts, can tip the balance for patients, some of whom go on to make important and lasting behavior change. \((9,22,23,41)\) Strategies for success at closing visits and arranging follow up are in DocCom module 12.

AnnotatedVideo (not shown in print-out text)

**BEHAVIOR CHANGE CHECK LIST**

Note: The editors think that the ASK-TELL-ASK technique presented in DocCom Module 10 is of particular relevance for behavior change conversations. We label many of the “5 A” skills listed below with an Ask or a Tell to underscore this relevance.

**PREPARE**

- Guide dialog to behavior change issue (lifestyle factor, treatment adherence).
- Summarize relevant prior discussion (or available facts).
- \((\text{Tell})\) Review association between a behavior and health risks.
- \((\text{Tell})\) Specify interest in discussing a behavior change that would benefit patient’s health.
- \((\text{Ask})\) Assess patient’s willingness to discuss this behavior.
- Negotiate agreement to discuss behavior.

**ASSESS**

- \((\text{Ask})\) Seek patients’ feelings, knowledge, beliefs and readiness about changing behavior.
- \((\text{Tell})\) Reflect understanding of patients’ perspectives.
- \((\text{Ask})\) Show curiosity and interest about patients and their context.
- \((\text{Tell})\) State respect for patient autonomy/choice.
- \((\text{Ask})\) quantify (1-10 scale) conviction.
- \((\text{Ask})\) quantify (1-10 scale) confidence.

**ADVISE**

- \((\text{Ask})\) Ask permission to provide advice or information.
- \((\text{Tell})\) Give specific advice (or endorse specific patient intention).
  - Give advice (or endorsement) in personalized, contextualized fashion.
  - Respond with reflection and empathy when patient shows anger, frustration, irritation, defensiveness, ambivalence, or embarrassment.
  - Respond with praise or appreciation when patient shows enthusiasm, interest or determination.

**AGREE**

- \((\text{Ask})\) Elicit and clarify patient’s goals.
- \((\text{Tell})\) Inform patient about health-promoting clinical goals.
  - Demonstrate a collaborative stance by using partnership skills.
- \((\text{Tell})\) Offer options that are appropriate to readiness, conviction and confidence.
- \((\text{Ask}, \text{Tell})\) Negotiate and compromise until you agree on realistic goals for change.

**ASSIST**

Modify and calibrate skills and strategies for different situations (different "Stages"), as follows:

No interest in change (**Precontemplation**):
• Show interest and concern using relationship building skills.
• (Tell) Recommend informative handouts.
• (Tell) Suggest role models, visit to a support group or habit diary.

Ambivalence about change (**Contemplation**):

• Underscore patient motivation through empathy.
• When patients express resistance, reflect content back to them.
• Affirm patient autonomy and choice.
• (Ask) Review patients’ understanding of the pros and cons of changing the behavior.

Ready for action (**Determination**):

• (Ask) Elicit patient’s options/ideas/strategies.
• (Tell) Suggest additional options.

Already making change (**Maintenance**):

• Celebrate success and affirm desired behaviors.
• (Ask) Seek details about temptations and / or lapses.

Resumed unhealthy behavior (**Relapse**):

• Re-invigorate plans by expressing both empathy for the relapse/guilt and partnership
• Identify and celebrate successes prior to this relapse.
• Explore which details of relapse situation are learning opportunities, and encourage trying again.
• Problem-solve methods to resist temptation.
• Make statements that affirm patient’s autonomy and choice.

**ARRANGE**

• Ascertain that patient understands details of action plan and agrees with them.
• Arrange follow-up visit, and appropriate referrals.

**APPENDIX: Additional content for concerned clinicians**

This section delineates additional evidence-based health behavior change models that clinicians could effectively add to their health system or office.

**A. Chronic Care / Self-Management**

**B. Communication principles that promote self-management**

**C. Social Cognitive Theory**

**D. Motivational Interviewing (MI)**

**E. Brief Motivational Interviewing**

**F. Integration of 5 A's and Chronic Care Model**

---

**A. Chronic Care / Self - Management**

The Chronic Care Model (CCM), developed by Edward Wagner and colleagues at the MacColl
Institute for Healthcare Innovation, has emerged as a tool for understanding and harnessing forces that influence the delivery and quality of care to patients with chronic illnesses. The stated goal of the CCM is to create an environment that supports “productive interactions” between “informed activated patients” and a “prepared, proactive team” of clinicians. Self-management support occupies a key position in the CCM, emphasizing that patients with a chronic condition must manage their own illness every day between health care visits.

Self-management support is defined as a patient-centered, collaborative approach that promotes patient activation, education and empowerment. The elements of self-management support include: 1) Assessment of beliefs, behavior and knowledge; 2) Collaborative goal setting; 3) Identification of personal barriers and supports; 4) Problem-solving; and 5) Developing a personal action plan that is based on the previous 4 steps.

Figure 2: Model for Improving Chronic Illness Care

In addition to “Self-Management Support”, the CCM specifies five other factors that influence “productive interactions” between patients and clinicians: 1) delivery system design (e.g., planned regular visits for patients with chronic illness, follow-up telephone contact for patients making a behavioral change); 2) decision support (e.g., care guidelines available at the point of care, clinician training); 3) information systems (e.g., patient registries, computerized reminder systems for patients and clinicians); 4) overall organization of health care (e.g., leadership); and 5) community linkages and resources. (48-50) The CCM is compatible with other models of patient-centered care. (1, 54, 55).

B. Communication principles that promote self-management

Roter and Kinmonth reviewed self-management interventions in diabetes care, (8) and found evidence supporting principles that promote effective patient-centered interactions.

1. Explore and Hear the Patients Perspective
2. Provide Emotional Support and Express Empathy
3. Provide Useful and Relevant Information
4. Negotiate a Plan
5. Anticipate Problems and Barriers and Identify Potential Solutions
6. Offer Ongoing Monitoring of Adherence and Adherence Difficulties
These principles may be applied across a variety of medical conditions and patient populations. The patient-centered and collaborative nature of these principles emphasize understanding patients' experience and showing empathy, negotiating goals and helping patients to identify and overcome barriers. These principles are echoed in other reviews about promoting self-management and health behavior change (7,9,30,47,56-58).

C. Social Cognitive Theory

Social Cognitive Theory (also known as Social Learning Theory) posits that behavior change and its maintenance depend upon a function of an individual's: 1) outcome expectations (i.e., beliefs about what might happen outcomes could result from engaging in a behavior); and 2) efficacy expectations (self-efficacy) (i.e., beliefs about ability to how capable or confident one is of performing specific the behaviors in specific situations). Said more simply, one's beliefs about the likelihood of an outcome and one's feelings of confidence about achieving an outcome are strong determinants of that outcome. Thus, interventions that increase a person's self-efficacy will improve behavioral outcomes. This might include (e.g., skills training with an opportunity to practice in real-world settings.) will improve behavioral outcomes. Another principle of Social Cognitive Theory, Reciprocal determinism, another principle of Social Cognitive Theory, holds that personal factors, behavior, and the environment interact in such a way there is a reciprocal interaction between personal factors, behavior, and the environment such that any change in any one of these elements has an influence on the others, "reciprocally". ThusFor example, success resulting from a new behavior, such as a behavior (e.g using a relaxation strategy to avoid smoking) may increase self-efficacy, which will then improves one's subsequent the ability to maintain smoking abstinence from smoking. The environment exerts an many effects on behavior in a variety of ways, including modeling, a powerful determinant of behavior change. Thus, repeated exposure to positive role models, such as peers with effective coping repertoires, promotes adoption of healthy behaviors.

Self-determination theory is a theory of human motivation that distinguishes between motivations that are autonomous versus "controlled" by others (such as "orders" from clinicians). Carefully designed and controlled studies show that autonomous, or internal, motivation is associated with improved better adherence and improvements in diabetes care. Moreover, clinicians who support patient autonomy and offer advice and treatment options "without pressure or demand" in a non-controlling, non-authoritarian way promote enhanced adherence and health behavior change.

D. Motivational Interviewing (MI)

Motivational Interviewing (MI) was developed by psychologists William Miller and Stephen Rollnick as an intervention targeting problematic alcohol and substance use. However, MI is increasingly being applied to other behaviors, including counseling to prevent HIV infection (32,33,59), diabetes (64), weight management / obesity(65), and anxiety disorders(66,67). This type of counseling is compatible with the models noted above, and relies on elicitation of patient beliefs, amplification of any positive inclinations towards changing a behavior and helping patients take charge of their change process. is an approach to patient counseling that is compatible with all the models noted above.

Rollnick and Miller have defined Motivational Interviewing as a collaborative, patient-centered
approach to interviewing and counseling in which the role of the practitioner is to evoke from patients their own reasons (that is, “motivation”) for making a change in behavior, rather than to impose the practitioner’s ideas about what patients should do. Helping patients to articulate their own values and goals can be a powerful motivator for change, especially when values they espouse are contrasted with their current behavior.

The process of evoking values and reasons necessarily requires active listening by clinicians. Active listening creates communicative space by asking open-ended questions, offering appreciative comments, and reflecting back to the patient brief summaries of what we understand the patient to be saying.

Generally, asking open ended questions about values and beliefs and restating patients’ answers (reflective listening) makes patients more likely to state their reasons for changing or not changing. Miller calls these patient statements “change talk,” and change talk in turn facilitates patients’ choosing to make a behavior change. Hearing their own “change talk” strengthens patients’ internal motivations and encourages movement in the direction of change. Other techniques for understanding motivations include eliciting what patients like and do not like about a current behavior (review the pros and cons) and using an importance/confidence scale, the answers to which facilitate patients’ talk about their readiness to undertake change. “On a scale from 0 to 10, how important is it for you to quit smoking? On that same scale, how confident are you that you can quit smoking?” Suppose the clinician reflects, “I hear that you want to be alive and healthy for your grandchildren.” An example of patient change talk might be, “Well, I did quit smoking for a while after my hip surgery.”

Clinicians’ tendency is to point out unhealthy behaviors and tell patients what they should be doing instead. This is the “righting reflex”–“You really should stop smoking or else you are going to have another heart attack.” Clinicians who respond to patients who are ambivalent about changing their behavior with a “righting reflex” statement typically and quite routinely cause patients to “defend” their current behavior. (“But... I’m under a lot of stress right now and smoking is my only stress reliever.”) Thus, succumbing to the righting reflex may solidify resistance to change.

If instead, clinicians resist the righting reflex by being curious, empathic, and supportive, they provide patients a potential space to verbalize any reasons for change that already exist within them. This can tip the balance in favor of change by producing change talk, and creating space for a continuing dialogue. Reflecting, “It sounds as if you really find smoking relaxing, and that’s what you feel you need right now,” might be followed by, “Yeah, but maybe there’s a better way to deal with stress than smoking...”

Listen especially for “commitment language,” that is, statements that show that patients are ready to take steps toward changing (“Starting tomorrow, I will quit smoking”), and reflect it back, (“Sounds like you have a first step in mind.”) Additionally, even if patients are not yet ready to take steps toward change, clinicians can support optimism and hope by stating our belief that they can change.

The “RULE” mnemonic describes four principles that underlie the MI approach to engaging patients in a back-and-forth dialogue rather than a prescriptive monologue.

1. Resist the righting reflex – avoid directing
2. Understand patients’ motivations – explore meaning, goals and values
3. Listen to patients – respond with empathy
4. Empower patients to make change – support self-efficacy

Table 4: Principles of Motivational Interviewing (From (67))

When clinicians use the steps outlined above, any change patients make is “autonomous,” or “self-determined.” In summary, clinicians engage patients in a facilitative dialogue; guiding patients in a process that research shows more often produces sustained change than more
E. Brief Motivational Interviewing

Brief versions of Motivational Interviewing have been developed for use by clinicians in primary care and other health care settings [33, 34, 62, 67]. They emphasize that progress can be made in brief interviews, and review simple strategies to build rapport (i.e., open-ended inquiry, reflective listening and empathy), to assess patients’ stage of change, and to ask about (1) conviction or importance regarding the need for change; and (2) confidence or self-efficacy about taking action. Clinicians can tailor counseling and use specific strategies that seek to foster and increase patients’ levels of conviction and confidence. As a general rule, if both conviction and confidence are low, investigators suggest that it is most efficient to focus on enhancing conviction first. After all, most patients have to believe it is important to change or adhere before they will be willing to invest energy in learning how to change.

Brief action planning (BAP) is a motivational interviewing-based communication tool developed by Steven Cole and others (www.CentreCMI.ca) that is designed to support self-management and motivate adaptive behavior change. The BAP suggests exploration of following core questions:

1. “Is there anything you would like to do for your health in the next week or two?” (what, when, where, how often, etc?)
2. “On a 0-10 scale of confidence, were 0 means no confidence and 10 means a lot of confidence, about how confident are you that you will be able to carry out your plan?” (If confidence <7, initiate collaborative problem-solving.)

These explorations often result in questions that can be followed up by a menu of options for treatment and follow-up; outlining development of specific, measurable steps toward change (e.g., reducing the number of cigarettes smoked per day or using condoms some of the time); eliciting elicitation of a commitment statement from the patient; and collaborative problem-solving and follow-up. Patients not ready to commit to any action towards change may be encouraged to continue to think about the possibilities for change while being told that help is available when they are ready to take action. For patients with low confidence, strategies include: reviewing past experience, especially successes; teaching problem-solving and coping skills; and encouraging small steps that are likely to lead to initial success.

F. Integration of 5A’s and Chronic Care Model

Figure 4 below illustrates an integration of Self-Management Support with the 5A’s counseling approach. (7)
5 As of Self-Management Support


**Figure 4:** Integration of Self-Management Support with the 5A’s

In this integration, each of the 5 A’s is associated with one of the key elements of self-management support.

**Figure 2: The Chronic Care Model**

If you reference the complete Chronic Care Model shown in Figure 2, you are reminded that self-management support is but one of several elements within the level of the health care organization that interact synergistically to promote “Productive Interactions” between a “Prepared Proactive Practice Team” and an Informed Activated Patient. Thus, improved health outcomes will be more broadly and deeply realized only when clinicians deliver effective patient-centered health behavior counseling (Tables 3, 4, and 5) within a context of care that includes all of the key elements of the Chronic Care Model.
Appendix 2: Additional tables and figures

In this section you'll find the following tables / figures:

1. Principles of Patient-Centered Counseling
2. The Self-Management Model
3. DocCom Video Skills Checklist for Behavior Change Counseling

1. Principles of Patient-Centered Counseling

A. Assess (before Telling)

- Strive to understand the patient’s perspective (experience, feelings, ideas, function, expectations)
- Assess readiness, conviction and confidence

B. Build Rapport

- Reflective listening
- Express empathy
- Provide affirmation and support

C. Tailor Counseling:

1. For Low Conviction
   - Provide information and feedback (with permission)
   - Explore ambivalence
   - Provide a menu of options and support choice and autonomy

2. For low confidence:
   - Review successful past experience
   - Teach problem-solving and coping skills
   - Encourage small steps

2. Self Management Model
In this section you'll find the following figures:

1. Conviction Scale
2. Chronic Illness Care Model
3. Self Management Model
4. 5 A's and Self Management
5. DocCom Video Skills Checklist

3. DocCom Video-Skills Checklist for Behavior Change and Adherence Counseling

Scoring Method:

- 3- Skill performed/displayed very effectively;
- 2- Skill performed/displayed somewhat effectively;
- 1- Skill performed/displayed but ineffective or incomplete;
- 0- Skill omitted/not displayed.

<table>
<thead>
<tr>
<th>Communication Strategy/Skill:</th>
<th>Performed?</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes Score 1-3</td>
<td>No Score 0</td>
<td></td>
</tr>
</tbody>
</table>

1. **Transition and Summary:**

1.1 Focusing of discussion to lifestyle factors, adherence to treatment recommendations or self-management

1.2 Summary given of relevant findings

1.3 Association made between lifestyle choices, adherence and consequent health risks
1.4 Beh.
1.5 Reflective, collaborative discussion style used.

2. **Assess : Eliciting Patient Reactions/Feelings/Beliefs**

2.1 Seeks to understand patient perspectives, feelings, and knowledge about health risk behaviors and reasons for adherence to treatment. Shows curiosity and interest.

2.2 Utilizes open-ended questions.

2.3 Utilizes reflective listening technique.

2.4 Responds with appreciation of patient perspective or empathy.

2.5 Conveys attitude of respect for patient autonomy/choice.

3. **Agreement on Behavior Change Agenda**

3.1 Negotiates agenda based factoring patient preference and identifies factor to discuss.

3.2 Displays patient-centered attitude.

4. **Advises to Change**

4.1 Gives advice/personalized message to change or adhere with treatment recommendations.

4.2 Responds to patient response with reflective listening.

5. **Assists with Stage-Specific Counseling**

5.1 Identifies clues to patient's stage of change and begins appropriate counseling pathway.

5.2.1 If patient is angry, defensive, ambivalent or embarrassed, responds with reflective listening and empathy.

5.2.2 If patient is enthusiastic, interested or determined, responds with praise.
5.3 Achieves Counseling Goals (Circle Appropriate Stage):

5.3.1 Pre-Contemplation: Raises **awareness** through understanding, empathy, education/handouts, suggestion for role models, support group, or habit diary.

5.3.2 Contemplation: Increases **motivation** through empathy, rolling with resistance, reflective listening, double-sided reflection, and/or decision balance.

5.3.3 Determination: Enhances **plan for success** by eliciting patient plans/strategies, using conviction/confidence scale, problem-solving to reduce barriers, help with action.

5.3.4 Maintenance: **Invigorates** action plan by celebrating success, affirming desired behaviors and what is working, addresses coping to resist temptation, inquires about mini-relapses or lapses.

5.3.5 Relapse: **Re-Invigorates** plan for change by expressing empathy for the relapse/guilt, reflecting on experience of success before lapse or relapse, examining "stinking thinking", enhancing coping strategies, encouraging trying again.

6 **Agreement on Next Steps**

6.1 Begin closure by asking patient to summarize the discussion or what they plan to do (rehearse action plan if appropriate; if early stage of change, may involve keeping a log, attending a class, or to continue the discussion at a future visit). Uses **ASK-TELL-ASK** technique.

6.2 Agree on plan or negotiate until some agreement is reached.

7 **Arrange Follow-up**

7.1 Schedule follow-up visit (short-term if action plan initiated); Refer for assistance as needed.
LITERATURE REFERENCES


68. Haidet P. Ann Fam Med. 2007;5:164-69
Welcome to DocCom Module 17:
Shared Decision Making

by Clarence H. Braddock III, MD, MPH

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:
Authors: Clarence H. Braddock III, MD, MPH
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patient: Alma Fuller
Rationale
Clarence H. Braddock III, MD, MPH

The Patient's View

The Doctor's View
Clarence H. Braddock III, MD, MPH

Questions for Reflection:
1. Why should clinicians involve patients in clinical decision making?
2. What role do patients want to play in decision making?
3. How do I determine how much involvement my patients want?
4. How do I promote patients’ involvement in clinical decision making?

Key Principles:
1. Ethics:
   Shared decision making arises from the dual ethical principles of beneficence and respect for autonomy: the clinician has an ethical obligation to provide best clinical advice and judgment
while offering patients a meaningful role in clinical decision making.

2. **Information:**
   In order to become an informed participant in clinical decision making, patients need adequate information about the nature of the clinical situation, alternatives, benefits and harms, and uncertainties, all in a manner which they can understand.

3. **Involvement:**
   The clinician should create an atmosphere that fosters patient involvement in decision making, encouraging questions and respecting divergent values and preferences.

4. **Partnership:**
   The ultimate goal of shared decision making is to reach a decision that both the clinician and patient support. This is accomplished through mutual participation, so that the patient gains from the clinician’s knowledge and judgment and the clinician learns the patients values and preferences.

---

**Learning goals:**

*At the conclusion of this module, you will be able to:*

- list and describe the key elements of shared decision making
- describe the ethical rationale for shared decision making
- involve your patients in clinical decision making
- explore your patients' desire for a role in decision making
- foster your patients' informed participation in clinical decision making.

---

**EVOLUTION OF CONCEPT OF SHARED DECISION-MAKING**

Recent acceleration in medical science and research left patients and potential research subjects with limited understanding of facts and potential implications of decisions about their health. A Presidential commission addressed these issues and articulated both the ethics and the process of getting people more involved with their own health.

Science and technology advanced at a rapid pace in the past few decades. Understanding information relevant to decisions about health became increasingly difficult for the lay public, and particularly for patients faced with the need to decide in situations that were urgent or carried lifelong implications. In the early 1980’s a Presidential Advisory Panel convened to address some of the complexity introduced by the rapid advance in knowledge and technology. This panel, on informed consent in health care and research, introduced the phrase “shared decision-making.” They advised:

*Ethically valid consent is a process of shared decision-making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of a particular treatment.* (1)
Shared decision-making acknowledges patients’ central role in making decisions about their own health care. The clinician’s primary role is to make health care recommendations based on the desire to promote patients’ well-being. The clinician’s second obligation is to help patients obtain and understand the information relevant to a particular health decision, and to facilitate their active participation in making the most informed decision possible. We emphasize that the clinician’s obligation goes beyond a unilateral disclosure of risks and benefits, and includes the specific intention to foster patient understanding, as well as targeted interventions to accomplish this intention.

**CONCEPT OF SHARED DECISION-MAKING DERIVES FROM FUNDAMENTAL ETHICAL PRINCIPLES**

The ethical principles of respect for persons, respect for autonomy, and promotion of patient well-being (beneficence) form the foundation for the concept of shared decision-making. The interactional and communication processes that drive the implementation of the concept derive from these ethical principles.

The principle of respect for persons derives from the view that people are valuable in their own right. Thus, clinicians have an obligation to show respect for the intrinsic value of each individual. One way in which the clinician can show respect is by fostering the meaningful participation of patients in decision-making.

The concept of autonomy is central to Western ethical traditions. An expression of respect for autonomy in the clinical context involves acknowledging and supporting patients’ right to make decisions that affect their bodies.

The principle of promotion of patient well-being, often called beneficence, is a central tenet of clinical medicine. As clinicians, we are guided by a professional obligation to use our knowledge and skills to evaluate patient concerns and make recommendations for beneficial health care interventions.

In some situations, you and your patients may define “benefit” substantially differently. Using the example of blood pressure control, medication side effects may affect quality of life so much that patients no longer perceive any net benefit. The purpose of shared decision-making is to facilitate patients’ role in determining the meaning of “benefit” in their own health care decisions.

**THE PATIENT’S ROLE**

Most patients want information, but some patients want clinicians to make important decisions for them, and some patients will defer to family. Ask your patients about their preferences.

In general 70-80% of patients, when asked their preference for involvement in decision making, express a desire to be informed and to have a say in the choice of medical treatment. (2,3,4) Nevertheless, some patients may be reluctant to participate, either because they truly would rather delegate decision making authority to the clinician, or because they simply feel overwhelmed or unaccustomed to the task. Hence it is important to inquire about the patient’s preference for a role in decision making. Checking regularly with patients will help you ascertain that you are not overburdening them with complex explanations, statements laden with medical jargon, or excessive detail in discussions of alternatives, risks, benefits, or uncertainties, and insures that your dialog is both relationship-centered and efficient. (see module 10)
Among patients of other cultural backgrounds, the default preference for involvement in decision making may not hold true. Rather, there may be traditions of allowing other family members to make decisions, or to withhold certain information on diagnosis and prognosis from the patient. Remain open to those patients who have a different view of how clinical decisions should be made. Additionally, do not make assumptions about patients’ desired level of involvement, ask them.

**Inviting patient involvement**

Balance your invitation, help patients understand what you mean, and encourage patients to think out loud.

Many patients are not accustomed to playing a role in clinical decision making. Patients may worry that you will be offended if they ask too many questions or seem to question your opinion or advice. They may also feel overwhelmed by the medical information, and embarrassed to admit this to you. For these reasons, talk with patients about the ways in which you will support and enable them to have a meaningful role.

As you talk, balance your encouragement, so that you neither force involvement, and nor inadvertently discourage a role. “You need to be involved with this decision,” may be too forceful. “You could also be a part of this decision,” may suggest that you don’t really want them involved. The best metaphor for encouraging the patient’s involvement is to think of it as an invitation:

"I really want to give you a chance to share your thoughts about this too."

"People differ in how much they want to be part of making choices about their medical care. How much do you like to be involved?"

In some instances, it may even be helpful to ask patients about their preferred decision-making style in a formal way. One tool that can help is the Control Preference Scale. This simple, one-page form uses simple cartoons and plain language to prompt patients to select their generally preferred style of decision making, from active, active shared, collaborative, passive shared, and passive.

Even with such an invitation, some patients may be quite uncertain what your intentions are, or what you want from them. One technique that can help is to suggest that patients “think aloud.”

"What are you thinking right now?"

If they can make their thinking transparent to you, you gain insight into their level of understanding, potentially finding key areas you can clarify. You can also uncover areas that you have not yet discussed, such as specific worries this patient might have. Addressing these concerns foster both patients’ understanding and their level of comfort with the decision.

**FRAMEWORK AND SKILLS TO FOLLOW UP AN INVITATION**

A general framework and a few associated skills enable clinicians to partner with patients in making personalized decisions about situations.

Many patients will accept your invitation to actively collaborate about important decisions. Patients’ need for information and their ability to handle it, the medical complexity of the information you
seek to help them understand and the urgency, importance and meaning of the situation vary tremendously. Is this a prevention discussion with a highly educated patient (“Your cholesterol is high,”) an urgent surgical situation for someone who speaks little English (“Your infected gallbladder should be taken out now,”) a proxy decision with a very worried parent (“Your baby is very jaundiced and needs hospitalization,”) or a simple matter with a retail clerk (“I do not think you need an antibiotic for your cold”)? Having a general framework in mind to remind you of the relevant elements and their associated skills enables you to flexibly handle this array of everyday situations competently, efficiently and in a personalized fashion that respects each person. The elements that you will include in your shared decision making conversations appear in the following list:

- Invite patients to participate
- Describe the nature of the decision that patients face
- Delineate alternative courses of action that could be taken
- Describe relevant information about the pros & cons of alternatives
- Present information about uncertainties inherent in the situation
- Assess patients’ understanding
- Ascertain patients’ preferences for action

Adjust your interventions to the situations’ complexity

Dialog will be longer or shorter, and the completeness with which you carry out the steps will vary according to your relationship with patients, their past experience with related decisions and the complexity of the situation.

Clearly the extent of dialogue necessary to foster informed participation will vary. Additional factors influencing the dialogue needed would be the length of your relationship with a patient, the patient’s experience with prior similar decisions and his or her cognitive ability. Importantly, the nature and complexity of the decision will strongly impact the extent of discussion. (5)

For some decisions of low complexity, only an abbreviated discussion is needed, letting the patient know what you would like to do and asking them if that will be all right. Some level of discussion of the nature of the decision is always necessary, such as, “I’d like to order a blood count to make sure you’re not anemic.” For many such basic decisions, there will be minimal if any “risk,” and the alternatives are rather limited, such as not ordering a blood count. Thus it is not crucial to routinely discuss these elements. The conversation should, however, leave open the door for patient questions or concerns, such that when the discussion is complete, patients have their information needs met. For basic decisions, this can be accomplished by merely asking, for instance, “Does that sound all right?”

The typical very complex example is a surgical procedure, in which there is substantial risk and clear alternatives. Here the need for exploration is greater. For the most complex decisions, explicit discussion of alternatives, risks and benefits, and a full exploration of the patient’s level of understanding and their opinion would be essential. Many decisions, such as prescribing a new medication, may need a level of discussion intermediate to these two extremes.

For some decisions, the amount and complexity of information may be so extensive that it is difficult to convey in a single clinical encounter. A decision aid can help in these instances. A
decision aid is a resource – booklet, DVD, video, or website – that provides information in a format and depth that is easily accessible. Decision aids have been shown to improve the quality of shared decision making, and an increasing number of decision aids are available for common conditions and decisions.

### Useful skills for these conversations

Learning key skills and practicing them increases trust and satisfaction through fostering a successful shared decision making process. Phrases similar to those below effectively convey your intention, the meaning of the situation and your personal concern that patients get what they want and need.

#### Your invitation to patients

- "This is really a decision we should make together"
- "It will be important to me to hear your thoughts about this too."

#### Description of the nature of the decision

A clear statement of what is at issue helps clarify what is being decided upon and allows clinicians to share their preliminary thoughts.

- "What we need to decide is..."
- "The issue for us today is..."

#### Delineating alternatives

A decision always has options, including the option of doing nothing at all. Taking a moment to make this explicit insures better patient understanding of the situation.

- "You could try the new medication or continue the medication you are taking."

#### Description of the pros and cons- benefits and risks

Clinicians frequently present the pros of one option and the cons of another, without fully exploring the pros and cons of each. A more balanced presentation assures that patients’ decisions will be better informed. In addition to clinical impacts of the proposed intervention, it’s important to address the real-world, functional implications. For example, the patient contemplating insulin therapy might worry about how they could incorporate insulin administration into their work or social life. Your proactive inquiry about these concerns may remove a barrier to patient acceptance of a beneficial treatment.

- "The new medication is more expensive. But you only need to take it once a day."

- "Let's talk about how this might affect your day-to-day life."

#### Present information about uncertainties

While sometimes difficult, a discussion of uncertainties is crucial for the patient’s comprehensive understanding about the options. Thoughtful discussion can promote trust and encourage compliance.

- "There is a good chance that this will help you."
- "This works well for most patients."
- "There is a small chance – maybe 1 out of 20 - of infection from this."

#### Assess patients’ understanding

Once the core information is provided and core disclosures are made, clinicians must check in with patients to know if what they have said so far makes sense. As emphasized above, fostering understanding is the central goal of shared decision making.
"Do you follow where I am going with this?"
"Does what I say make sense to you?"
"Are you with me so far?"

Sometimes it is important to delve more deeply into the patient's grasp of the dimensions of a decision, particularly so for a complex decision. In such instances, the use of questions that encourage the patient to share their understanding of the decision can be very helpful. This approach is often called the "teach-back:"

"I know we've covered a lot, and I want to make sure I did a good job of explaining. It would help if you could repeat what you understood me to say."

**Ascertain patient preferences for next steps**
Experience demonstrates that many patients need encouragement to actually state an opinion, particularly if they disagree with clinicians' initial recommendations. A common clinician error with serious consequences is to assume that silence means that patients do not disagree, and “consent” to your plan. Patients who disagree and do not say so are less likely to adhere to decisions, and (for example,) may not show up for their scheduled consultation or biopsy, increasing costs, adding delays and unnecessary frustration and inefficiencies. Make certain that your patients know that you wish to air any disagreements and that you will listen and explore possible alternatives graciously, including giving them more time to consider their options, consult their loved ones, and so on.

"Does that sound ok with you?"
"What do you think?"
"What would seem like the right course of action?"
"How do you feel about that?"

---

**EXAMPLES OF SHARED DECISION MAKING**

<table>
<thead>
<tr>
<th>Complexity of decision</th>
<th>Poor example</th>
<th>Better example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic:</strong> obtaining a complete blood count</td>
<td>&quot;I'd like to check some blood tests. Here's the slip to take to the lab.&quot;</td>
<td>&quot;I think we should check your blood count to see if that is causing your fatigue. Does that seem reasonable?&quot;</td>
</tr>
</tbody>
</table>

**Intermediate:** change in blood pressure medication

<table>
<thead>
<tr>
<th>Poor example</th>
<th>Better example</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I'd like you to increase the dose of atenolol you're already taking.&quot;</td>
<td>&quot;We need to control your blood pressure better [2]. We could increase the dose of your atenolol or add a medication like a water pill [3]. The higher dose of atenolol might make you feel fatigued, but the water pill might make you urinate a lot at the beginning. Does that make sense to you? I'd suggest increasing the atenolol; what are your thoughts?&quot;</td>
</tr>
<tr>
<td>&quot;It might be a good thing to check you&quot;</td>
<td>&quot;At your age, we should start thinking about screening for prostate cancer. You've probably heard about the PSA test. It can detect very small prostate cancers but it can also be abnormal if your prostate is enlarged, even if there's no cancer. Unfortunately,</td>
</tr>
</tbody>
</table>
Complex: prostate specific antigen testing for prostate cancer. Here’s the slip to take to the lab."

we’re not certain that finding prostate cancer early will help you live any longer. We could do the test or not. Every man has different opinions, and well-informed experts disagree, so I would like your views in this decision. Do you have any questions about the test? ......What’s your thinking, then, about a PSA test?"

Annotated Video (not shown in print-out text)

2 examples of problematic decision making

Review these two video clips (the initial 15 seconds are the same for both movies).

Click on the picture-button above to see Movie ONE

Click on the picture-button above to see Movie TWO

What makes these interactions problematic? What is the difference between them? Is it sometimes appropriate for clinicians to frame medical decisions in this way?

CONCLUSION

The goal of shared decision making is to foster patients' informed participation in decisions about their health. Shared decision-making rests on the ethical principles of respect for persons and autonomy and promotion of patient well-being. Evidence in the medical literature shows that involving patients in decision making promotes trust and satisfaction and contributes to better clinical outcomes.

Several recent studies confirm that most patients would prefer a role in decision making. Do not make assumptions about your patients’ desired level of involvement. Remain open to those patients who have a different view of how clinical decisions should be made.

To practice shared decision-making effectively, clinicians need both a framework to guide such discussions and the communication skills to implement these conversations. Key elements of shared decision making include: invite patients to participate; describe the decision; delineate alternatives; describe pros & cons of alternatives; present information about uncertainties; assess patients’ understanding; and ascertain patients’ preferences.

Clinical decisions vary in complexity, from very simple to extremely complex; therefore,
discussions about decisions will vary greatly depending both on the patient and the complexity of the issue.

BEHAVIOR SKILLS CHECKLIST

1. Discuss the patient’s role in decision making
2. Explain the nature of the clinical issue or decision
3. Discuss alternatives (including no action)
4. Discuss the pros/cons and the uncertainties of alternatives
5. Assess the patient’s understanding of the issue
6. Ascertain the patient’s informed preferences

LITERATURE REFERENCES

2. Charles et al. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). Social Science and Medicine. 1997; 44:681-92

loading..
Welcome to DocCom Module 18:
Asking about Sexuality

by Richard M. Frankel Ph.D., Sarah Williams M.D., Elizabeth Edwardsen M.D.

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Richard M. Frankel Ph.D., Sarah Williams M.D. and Elizabeth Edwardsen M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patients: Ashley Novack, Mike Ondri, Dorothy Winters
Clinicians on camera: Richard M. Frankel Ph.D., Sarah Williams M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.0 - 1/13/2012 Enhanced with HTML5 code and MP4 videos
2.0 - 8/5/2009 Update to DocCom Version 4.0
1.0 - 7/22/2005
Rationale
Richard M. Frankel Ph.D.

The Patient's View

The Doctor's View
Sarah Williams M.D.

Questions for Reflection:

1. How comfortable are you at routinely asking patients about their sexuality?
2. What questions about patients' sexuality and sexual practices are the most difficult for you?
3. What types of patients or patient responses about sexuality are the most uncomfortable for you?
4. If you find yourself feeling attracted to a patient, what communication strategies might you employ?
5. If you get the sense that a patient is attracted to you, what communication strategies would you employ?

Key Principles:

1. Patients want to discuss sexual concerns with their clinicians, but seldom bring up these concerns spontaneously.
2. Clinicians must initiate discussions with their patients about sexual functioning and relationships.
3. Clinician-centered concrete and directed questioning is important in exploring delicate topics like sexuality and sexual practices.
4. Embarrassment or uncertainty about their knowledge and skills prevents many clinicians from providing high quality care to patients with sexual concerns and problems.
5. Attending to self-awareness and to practicing their skills enables clinicians to overcome their personal barriers, and to engage in helpful discussions with patients about sexual issues.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe the rationale for routinely asking sexual history questions in medical interviews
- Demonstrate the skills of engaging patients in conversations about their sexual relationships and concerns
- Describe the continuum of sexual boundary issues in patient care and demonstrate skills in responding effectively to patients who cross boundaries.

INTRODUCTION: EVIDENCE ABOUT SEXUALITY IN MEDICAL PRACTICE

Evidence shows that inquiry about sexuality and sexual behavior, as well as examinations of breasts, rectum and genitals remain problematic for many clinicians. In addition, clinicians’ opportunities to talk about their clinical experiences with the topic of sexuality, their own sexuality and sexual feelings in the practice of medicine, are limited. These problems may greatly diminish the quality of patients’ care.

You’ve just taken over Dr. Smith’s practice and are seeing a long-term patient for blood pressure management. The patient is very friendly, and comments on your clothing, your new office décor and the fact that you do not wear a wedding ring. You notice that the blood pressure medication was changed last visit because it was causing sexual dysfunction; your anxiety rises as you anticipate that you’ll need to do a sexual history.

- Focus groups reveal that patients prefer that their clinician initiate any discussion about sexual functioning.
- The Survey on Sexuality in Nursing Practice (SSNP) found that only 12% of nurses addressed sexuality with their clients even though the nurse/subjects consistently identified sexuality as a necessary part of nursing practice.
- Emergency room clinicians and Nurse Practitioners, even when prompted by a computer screening program that indicates a patient is at risk, or is currently a victim of intimate partner violence (including sexual abuse), rarely inquire about the details of the abuse.
- A study of screening for HIV risk demonstrated that many practitioners encountered “awkward moments” with their patients in their discussions of risky sexual practices that limited the accuracy and effectiveness of the screening.
- Many patients experience disruption of normal sexual activity as a result of medication side effects, disruptions in family functioning and psychological fears following surgery.
- Nearly 75% of older patients would like to discuss some aspect of sexual functioning with their clinician but less than 2% of primary care clinicians routinely ask their older patients...
questions about their sexual health.

- A study of women with GI complaints found that a significant proportion had a history of early childhood sexual abuse that was undetected in previous medical encounters.

- Many medical students, residents and practicing clinicians can identify instances of sexual boundary confusion (e.g., feeling attracted to certain patients, not doing breast or genital exams on patients who are about their age) but do not have opportunities to discuss their feelings with colleagues.

In this module we identify basic principles of taking the sexual history. We offer a framework for approaching the interview and some practical suggestions for ways to normalize sexual history and make it a routine. Second, we focus on special situations, such as interviewing patients with STD’s, and chronic illnesses or situations that may lead to sexual problems. Third, we explore clinician sexuality and personal issues that inhibit treating patients appropriately.

---

**PRINCIPLES OF SEXUAL HISTORY TAKING**

In this section, we'll cover the following:

- **When to ask about sex?**  
  At what point in the encounter should you initiate conversations about sex and sexual function?

- **What is the most respectful way to ask about sex?**  
  Learn the health reasons for asking about sex, the questions you will need, and helpful transition statements.

- **What questions should I ask?**  
  Introduction to recommended questions for the routine sexual history.

- **How can I respectfully explore details and the context of sexual issues?**  
  Learn the best strategy to get more details about sexuality or sexual functioning in this or in a subsequent visit.

- **Talking to patients about HIV/AIDS or STDs**  
  Stigma and guilt are associated with HIV and other STDs and with behaviors associated with transmission of these diseases.

- **Talking about sex after patients’ surgery, or with those who have chronic illnesses**  
  Learn to anticipate the fear and symbolic effects of surgery in conversations with patients before surgery occurs.

- **Talking with teenagers about sexuality, STDs and pregnancy**  
  Learn what teenagers need in order to have conversations about sex with a medical professional.

---

**When to ask about sex**

As a medical professional you should be the one to initiate conversations about sex and sexual function. Certain types of interviews, such as comprehensive evaluations, expressed concern about any aspect of genitourinary function, or expressed sexual concerns call for
Evidence suggests that many patients have questions about their sexual functioning that they would like to discuss with their clinician. Like other sensitive topics, (living wills, costs, etc.), patients strongly prefer that the conversation be initiated by the clinician. Patients are unlikely to bring these topics up spontaneously.

During any visit that includes past medical history, social history and systems review you will ask questions about sexual health and function routinely, just as you ask about alcohol, drugs, relationships and other sensitive topics.

In less comprehensive visits, you will ask these questions when the “present illness” relates in any way to genitourinary function (including possible pregnancy), when sexually transmitted infections are a consideration, or when you had recently started patients on medications that may impair sexual functioning. Of course, you will address all aspects of sexual health and function whenever the patient’s visit is precipitated by a sexual concern or problem.

Some patients will refer indirectly or obliquely to questions about sexual functioning. For example, a patient recently put on medication for high blood pressure may ask in general terms about side effects or express concerns about physical activity. Often Ask a follow up question to ascertain whether the patient is worried about sexual function, and attend carefully to the non-verbal aspects of the communication.

What is the most respectful way to ask about sex?

Learn the health reasons for asking about sex, the usual questions you will need, and helpful transition statements.

Social scientists point out that sexual mores differ from culture to culture, sometimes making it difficult to discern the limits of propriety and decency. For example, it would be very unusual for a woman to see a male clinician about her sexual health in many cultures. Likewise, displaying parts of the body such as the soles of one’s feet is considered the equivalent of “exposing oneself” in some cultures. Understanding that norms differ, even within your own culture, is important in your providing a safe context for talk about sexual health and functioning.

Your ease in taking a sexual history is related to your own level of comfort with this portion of the visit. Learning the typical and appropriate questions, and becoming clear about why you are asking about sexuality are important steps you can take to reduce your own anxieties in this situation. Just as you learned to listen to the heart and eventually were able to detect subtle signs through repeated exposure, practice is the most important key to competence in this arena. Most patients appreciate that questions about sex may provoke some tension or embarrassment (particularly for student learners), and a transition statement such as, ”Now I’m going to ask you some questions about your sexual health,” and, ”These are questions I ask all patients and are important for your health,” usually readies both you and your patient to discuss this material.

What questions should I ask?

Below are recommended questions for the routine sexual history.

Usually, clinicians ask about sexuality during the psychosocial history. Some questions should be routine, others asked if patients indicate that there are issues about their sexuality they would like to discuss.
Check out the video example about "taking the sexual history" on the left.

Routine questions:

"Is there someone special in your life? Are you and this person having sex?"

"Are you satisfied with your sex life?" Or, "are there any problems or concerns about your sexual functioning that you’d like to discuss?"

Do you have other sexual partners? (are you monogamous, have multiple partners, casual partners)?

"It’s important that I ask some questions to assess your risk of sexually transmitted diseases or HIV: Have you been having any high risk sex? (injection drug users, cocaine users, prostitutes, gay or bisexual men)?"

"Has your illness affected your sexual functioning?"

Some experts recommend asking, "Do you have sex with men, women, or both?" However, frequently patients will tell you this information in answering the questions above.

Attend to the timing of discussions of sexuality and sexual functioning. Ideally, the patient and provider should be seated comfortably and at ease. If using an electronic medical record, keep note taking to a minimum and give full visual and non-verbal attention to the patient. Sometimes when you ask patients if they have any sexual problems or concerns, they will answer "no," but seem hesitant in their responses. Monitoring both verbal and non-verbal behavior to detect signs of anxiety or ambivalence about discussing sexually related problems. It can be helpful to notice that: "You seem a little doubtful." "I get the feeling that everything isn’t so great." Many patients will then be encouraged to reveal their concerns. For some patients, a statement about confidentiality will be helpful, "Everything we talk about will remain between you and me."

Many situations will require that you ask more details, such as the questions below:

"Are you using condoms to prevent disease? What percent of the time?"

"Do you have any other sexual relationships that I should know about?"

"Do you have difficulty having an orgasm?"

"Do you use any sexual performance enhancing medications (Viagra, etc)? If so, how frequently?"

Gender-specific questions:

<table>
<thead>
<tr>
<th>Men:</th>
<th>Women:</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Do you have any problems developing or maintaining an erection?&quot;</td>
<td></td>
</tr>
</tbody>
</table>
“Do you have trouble ejaculating too soon, or not soon enough?”

“Do you have any pain during intercourse?”

“Do you have problems with lubrication?”

(For men with erectile dysfunction):

“Do you ever get spontaneous erections? If so, are they normal?”

How can I respectfully explore details and the context of sexual issues?

The best strategy to get more details is to tell patients that you would like to explore further with them, in this or in a subsequent visit. Many sexual issues involve the broader psychosocial context.

Check out the video example about "the context of sexual issues" on the left.

Often when patients bring up sexual problems, they are associated with other problems in their relationships or in their lives. Respectfully asking patients to say more, and simply listening to them often provides an opportunity for helpful ventilation of feelings, and for revealing information that will help you decide on next steps. It is critical to listen and respond non-judgmentally and with empathy to these very sensitive issues.

As you transition to exploring the context in which the problem is experienced, some closed and some open questions that will help you respectfully get important medical and contextual details are listed below:

*When did you first become aware of this problem?*

*Has the problem occurred before?*

*Does the problem occur all of the time or just some of the time?*

*(If there are multiple partners,) does it occur with all partners or just some partners?*

*What feelings does the problem raise in you?*

*How has your partner(s) been responding?*

*What have you tried to address to this problem?*

*Has anyone tried to hurt you or force you to have sex now or in the past?*

Sometimes patients will share information about maladaptive behaviors. In those cases, provide a rationale for continuing the conversation e.g., "I’d like to talk with you (today/next time) about your having unprotected sex with men and women because it carries increased risk for sexually transmitted diseases and HIV infection.” State that your interest is in their health risk; not in their sexual preferences or life choices, and reinforce that any information shared will be confidential. Be aware that further inquiry about maladaptive behavior in the moment may interrupt the patient from continuing the story and limit your understanding of what is going on in the patient’s life. If you feel that you don’t yet fully understand the context of
illness, simply flag the issue for later discussion and encourage the patient to continue.

Talking to patients about HIV/AIDS or STDS

Stigma and guilt are associated with HIV and other STDs and with behaviors associated with transmission of these diseases. Clinicians are not immune to related negative feelings about the diseases or the behaviors. When clinicians’ and patients’ ambivalent or judgmental feelings collide, defensiveness, irritation and anger frequently surface.

In most societies, sexually transmitted illnesses are shameful, and people who carry them are stigmatized, especially if the infections were acquired by disapproved sexual activity (outside of marriage, or through anonymous homosexual or heterosexual encounters, for example). For people with HIV/AIDS or at risk of contracting it, a fear of having a dreaded disease contributes further to the complexity of interviews. Where there is shame, there is often guilt. This is certainly true for patients with STDS and HIV/AIDS, particularly if the infection was contracted through behavior that goes against their moral or religious beliefs.

Check out the video example about "embarassement and guilt" on the left.

This video is an excerpt of a longer video from DocCom module 5. The clinician on camera is Auguste Fortin.

Guilt may be stronger if the infected person is putting someone else at risk because of the behavior, for example, a man who contracted HIV through IV drug use or sex with prostitutes, and is continuing to have unprotected sex with his wife. It is always a good idea to provide patients a chance to talk about their feelings(m 3, 6, 13) once the behavior and situation have been adequately understood; and this is never more true than when in dialogue with patients about HIV or other STDs.

Because issues related to STDs and HIV are so sensitive, your questions must be framed in non-judgmental language, and your non-verbal communications should be congruent, and neutral in tone. Many patients are already fearful of having HIV/AIDS, even when the actual likelihood of being infected is unclear. While you can’t change that probability by how you talk with patients, they are very sensitive to the nuances of your communications. Take extra steps to maintain a professional and objective stance, so that you avoid any implication that the probability is high, and avoid frightening patients unnecessarily.

Interviews are also complicated because these diseases, the behaviors through which they are contracted, and the fact that they can be transmitted to “innocent bystanders” bring clinicians’ fears, ambivalence, or judgments to the surface. Whatever you may feel about someone who engages in such behavior, it is not helpful to convey your judgments. Come to terms with any evaluative feelings you have about these diseases and the associated behaviors. If you have not, then your non-verbal signals will convey the judgments that you feel. The patient will see your mixed message, and will correctly believe that your non verbal communication conveys the truth about how you feel. Sending mixed messages confuses patients and diminishes trust. Again, practice, feedback and experience bring comfort and skill to your interviews about sex and sexual functioning.
Talking about sex after patients’ surgery, or with those who have chronic illnesses

Fear and symbolic effects of illness and surgery on sexuality usually cause patients more difficulty than physical effects. Medications’ effects on sexual function are diverse and frequent. Elicit details about the situation, and then explore feelings and relationships.

As stressed earlier in this module, patients seldom initiate conversations about sexuality, so clinicians should do so with chronically ill or post surgery patients, and those affected by medications. Be sure you ask directly, “how has this illness affected your sexual function?” If there are problems, ask about the details, and explore the patient’s emotions and the effects of the problem on the relationship.

Chronic diseases and surgery affect sexuality in a number of ways, including mechanical (e.g., arthritis, surgical wounds), physiological (e.g., fatigue or shortness of breath), or direct (e.g., endocrine or neurological disorders.) More often overlooked are the effects of illness and surgery on self image and self esteem, and on a patients’ sense of themselves as attractive, “whole”, men or women. For example, a colostomy or disfiguring surgery may diminish the sense of body integrity and cause people to fear they’re repellant to their partner, while a woman who has just had a hysterectomy or mastectomy may worry about her identity and value as a woman.

Myocardial infarctions and open heart surgery are frightening for both men and women, as they fear that sexual activity may precipitate another heart attack or cause other damage. Recall that for many patients the emotional and symbolic effects of illness or surgery are more powerful than the physical effects on sexuality. This commonly occurs following an MI or cardiac surgery that affects men’s sense of masculinity. Many drugs used for chronic illnesses can affect sexual function (usually desire, erection or arousal, or, primarily in women, orgasm).

Additional interviewing points for these patients are the following:

Be aware that emotional and symbolic effects are usually more devastating than the more obvious physical effects.

Do not make assumptions, (for example that a person with a disfiguring or debilitating illness is not interested in sex), inquire.

Get specific and appropriately detailed information about the behaviors and situation, and then ask about feelings. It may be awkward for young clinicians to ask about these details of sexual relations, but if you ask about them directly, patients will often answer directly. For example, does the patient with severe arthritis have difficulty opening her hips, or bending her knees? Have she and her partner talked about alternative positions, and is he willing to try these? If there is a lack of excitement or desire, does this seem due to pain, or fatigue, both, or neither? And so on. Then you can and should ask how she’s feeling about the situation, how it’s affecting the relationship with her husband, and what her worries or questions might be.

Be especially vigilant about the effects of major life stressors such as divorce, re-marriage, or spousal or family health on sexual functioning; and about the relationship of such events to patients facing or undergoing surgery.

Talking with teenagers about sexuality, STDs and pregnancy
Teenagers need healthcare providers who are trustworthy, empathic listeners, and who give good practical advice. When interviewing adolescents and young adults, ensure and emphasize confidentiality, initiate the topic of sex, give advice and sexual information respectfully and without condescension, and pay particular attention to inquiry about sexual coercion or abuse.

Check out the video example about "interviewing a teen about sexuality" on the left.

Teenagers are working out who they are and sexuality is a big part of this process. However smart and sophisticated teens may seem, they are still developing the ability to make good decisions, balance risks and benefits, consider future consequences, and perform other “executive functions”. Despite this immaturity and also because of it, teenagers react strongly to advice, even when it’s thoughtful and well-intentioned. They are sensitive to condescension, being treated like children, or being criticized. They tend to somewhat distrust adults, and—often rightfully so—fear that what they tell clinicians will get back to their parents. Therefore, the first rule is to ensure confidentiality.

At the same time, most teenagers respond positively if you convey a genuine interest in their experience and opinions, and a respect for the maturity they do have. It may be helpful to start with closed questions that help you get a clear sense of the behavior or situation, and then open the interview up for the patient to ask questions, or voice concerns. Keep in mind that most teenagers are embarrassed by talk about the details of sexual behavior, so be gentle in your questioning, and ask if it is ok to ask for more details, if they are needed to understand the nature of the problem. Sex education delivered in a factual nonjudgmental way is also helpful, as many teenagers lack realistic, accurate information about sexual functions, pregnancy and birth control, and STDs. They appreciate getting reliable, frank, information from someone they trust, laid out in a way that respectfully allows them to consider it and make their own decisions. Written resources are particularly helpful in presenting this complex and sometimes embarrassing or disturbing information. It may be helpful to have the discussion of sexuality and sexual behavior over time, a luxury that most primary care clinicians can offer their patients. If you think that a teen is at high risk, have the discussion in the index visit.

Finally, most teenagers are concerned with projecting the right image. Knowing little and without experience, most young people find it difficult to clarify their needs and desires, much less express them. Girls are often the ones in position to say “no” or “yes” to older boys’ or men’s demands, and are especially vulnerable to unhappy, coercive or even abusive sexual experiences. Remain alert for clues to the possibility that patients are in a tough situation sexually, and need an opportunity to talk. It is often important to ask directly about this. “What happens when you and your boyfriend argue?” “Does he ever threaten you or hit you?” “Are you ever in a situation where he forces you to have sex?” In a future module, we will thoroughly discuss how to diagnose and respond to physical and sexual abuse.
In this section, we'll cover the following:

1. **Sexuality and sexual feelings**
   Conscious and unconscious feelings about sexuality can interfere with your communications and distort your relationships with patients.

2. **Relationship Boundaries and Professionalism**
   Boundaries are the implicit or explicit limits that allow for a safe professional connection between a clinician and patient.

3. **Identifying and managing “seductive” behavior**
   Seductive behaviors are any verbal or nonverbal cues that seem to invite sexual activity. They may be intentional or unconscious; they are socially determined; they are inappropriate and invariably confusing in medical practice settings.

   - **Some reasons people exhibit seductive behavior**
     Many people display seductive behaviors.

   - **Sample Video**
     About seductive behavior

   - **Responding to seductive behavior**
     Become more self-aware of your feelings and behaviors. Respond directly to seductive behavior. Talk with colleagues.

---

**Sexuality and sexual feelings**

Conscious and unconscious feelings around sexuality can interfere with your communication and distort your relationships with patients.

Sexual feelings occur in the everyday lives of doctors, nurses, therapists and patients alike. They occur normally and naturally when professionals interact with patients and with one another. Problems arise when normal sexual feelings become distorted, projected or acted out in the professional-client relationship.

Conscious and unconscious thoughts and feelings around sexuality often interfere with the delivery of recommended physical examinations and treatment. It is not unusual, especially early in their careers, for male clinicians to “defer” doing breast, rectal or pelvic exams in young women, and for female clinicians to leave out doing genital or rectal exams in young men. Many clinicians, because of feelings of attraction or fears related to sexuality or cultural norms are inhibited in asking about patients’ sexual health. At the other end of the spectrum are clinicians who cross boundaries and engage in sexual relationships with patients. These inappropriate relationships and can lead to devastating consequences for both parties. All clinicians, especially trainees, must have opportunities to discuss their concerns around sexuality in clinical care and to work out strategies for addressing these concerns in order to deliver appropriate patient care.

---

**Relationship Boundaries and Professionalism**

Boundaries are the implicit or explicit limits that allow for a safe professional connection between a clinician and patient.

**Boundary confusion** occurs when the clinician or the patient becomes aware of unusual feelings about sexual issues in the relationship. In one study 72% of 392 psychiatry residents, (86% of men and 52% of women) reported sexual attraction to patients. (Gattrell et. al. 1988)
**Boundary crossings** occur when clinicians or patients begin acting upon their sexual feelings. Their relationship appears increasingly sexualized, but nothing explicit has been said or done. As each person’s perceptions become clouded by his or her own desires and fears, it becomes increasingly difficult to understand the meaning of the other’s behavior. In Gattrell’s study 11% of residents believed that one or more patients were aware of their attraction.

**Boundary violations** occur as the sexual dimension of a clinician-patient relationship becomes more explicit, understood and acted upon. Gutheil and Gabbard suggest that sexual misconduct, the most serious form of boundary violation, begins with relatively minor boundary crossings that “. . . show a crescendo pattern of increasing intrusion into the patient’s space that culminates in sexual contact. A direct shift from talking to intercourse is quite rare.” Peterson suggests that, “In every story of a (boundary) violation . . . four motifs surface: 1) a reversal of roles (the patient takes care of the doctor), 2) a secret (shared intimate feelings), 3) a double bind (it is impossible to stay in or get out of the relationship), and 4) an indulgence in professional privilege (the doctor prevails upon the patient to meet a personal need).” Gattrell found that 1% of residents acknowledged sexual contact with patients (all, in retrospect, regretted it). A parallel finding from this study was that 4% of men and 6% of women acknowledged sexual contact with their educators—clinical supervisors, course instructors, advisors and administrators, suggesting a possible parallel process of boundary violations in professional training activities that is transferred into practice. (Module 41 is about Boundary issues.)

---

**Identifying and managing “seductive” behavior**

Seductive behaviors are verbal or nonverbal cues that are perceived as inviting a sexual dimension into the relationship. They may be intentional or unconscious; they are socially and contextually determined; they are inappropriate and invariably confusing in medical practice settings.

Some people are “exhibitionist”, and may be overly made up or over dressed, or dressed so as to reveal more of their body than needed for their work or for a physical examination. Others are more overtly seductive and act coyly or are flirtatious, employing facial expressions, movement, gait, gestures, and verbal innuendo that is (are) invitations to sexual activity, while an occasional person will make openly erotic invitations to sexual activity.

---

**Some reasons people exhibit seductive behavior**

Many people display seductive behaviors. Some have psychiatric illness, some confuse intimacy with sexuality, and much more commonly, people unconsciously reenact and project feelings about someone who is not in the room.

Patients may unconsciously carry feelings and behaviors about significant people from their past into their current medical relationships. Without any conscious awareness of what is happening, such individuals reenact their feelings and behaviors as if the clinician were the significant other person. This is called *transference*.

Clinicians also may unconsciously reenact feelings and behaviors carried over from significant past relationships, and with no conscious awareness invite a sexual dimension into the relationship. This is called *counter-transference*. Clinician *counter-transference* is likely to show up or be exaggerated during periods of feeling isolated, depressed, chronically stressed or fatigued.

Some people learn that intimacy in any form is an invitation to sexual intimacy, or have never experienced intimacy except for sexual intimacy. For them, any opening to share important
experiences and feelings becomes defined in sexual terms, and experienced as an invitation to sexual activity. At times patients’ response to successful treatment is expressed in this way.

People with certain psychiatric disorders, such as somatization disorder, borderline or histrionic personality disorders, schizophrenia, and persons who have been abused sexually, physically, or emotionally (PTSD), may have symptoms that include a component of seductive behavior.

---

**Example Video**

Check out the video example on the left and consider the questions below.

Questions:

How effectively did the clinician in this video respond to this patient?

How would you respond?

---

**Responding to seductive behavior**

Become more self-aware of your feelings and behaviors. Respond directly to seductive behavior. Talk with colleagues.

Sexual feelings and unconscious counter-transference are normal for all clinicians. As a matter of both professionalism and better communication, we owe it to ourselves and our patients to become aware of our sexual feelings and associated behaviors. As lifelong learners we should continue to expand awareness about how they affect our relationships.

In the video example above, the clinician could have immediately expressed concern about the inappropriate past relationship with the volleyball coach, and asked about it. He could have asked about a past history of physical or sexual abuse, depression, or low self-esteem, which may precede maladaptive sexual behaviors. By focusing on the patient and understanding the origins of a patient's behaviors, you keep the conversation in the clinical realm, on the goal of understanding the patient's perspective, and on helping the patient. After examining and eliminating your own motives and feelings, noticing that a patient is flirtatious can serve as a clue to identify potentially serious psychopathology. On the other hand, responding positively to a flirtatious patient may be a warning that there are unresolved relationship issues in your own life that you need to address.

In interviews with patients, you can begin to respond effectively to seductive behavior by addressing it, and setting limits. For example, it is common for male patients to flirt with young women clinicians. Sometimes these patients are elderly or seriously ill, and the clinician interprets the comments as a defense against illness, and is not offended. Sometimes a patient will make an exploratory flirtatious comment. If you respond with a non-verbal message of disapproval, or
ignore the comment, and continue with the clinical interview, the patient will often get the message. But if the inappropriate comments continue, it is best to address them directly: "Perhaps you don’t mean to offend me, but I find your comments offensive. Comments like this will get in the way of my giving you appropriate medical care.” If comments still persist, it is often best to leave the room and bring back a more senior clinician. If situations seem to arise frequently, it can be helpful to reflect on your own behavior, and discuss this in a safe setting with trusted colleagues and mentors. L.J. Pitkow, at the time of taping a fourth year student at Drexel College of Medicine, demonstrates responding to seductive patient comments in the videos below:

Example Videos: Please click the picture buttons to play back the videos

Sometimes difficult situations can arise out of the best intentions if the clinician has not reflected honestly on the presence of covert sexual feelings in both clinician and patient. One attending clinician shared this story:

"A second year resident told me about a patient he was caring for. She was a young woman who had been very overweight and who had gained most of her weight in the last two years as her marital relationship became more problematic. The resident talked about how he really liked this young woman, had spent a lot of time in counseling her and she had lost 40 pounds. He added, 'she really looks great now!'"

"I told him I thought he was in potential trouble, but he denied there was any problem. The next day the resident called me in a panic. 'Can you come down to the clinic? She kissed me!' I asked, 'What did you do?' He said, 'I kissed her back–I didn’t want her to feel rejected!' I said, 'I’ll be right down.'"

"I spent time with them together, and talked with the patient about what had happened. She acknowledged she was falling in love with her clinician as a way to avoid dealing with her relationship issues. She agreed to go for counseling. And the resident learned a valuable lesson about boundaries, and paying attention to his feelings in patient care."

We would add that the advice to seek counseling applies equally to the resident. It is one thing to cross a boundary of sexual feelings for a patient and quite another to change one’s behavior and self awareness to guard against such things happening in the future. Professional counseling may be the best route to ensure success in this situation.

SUMMARY

Interviewing about sexual matters is an important and routine part of medical encounters and avoiding this topic risks limiting patients’ healthy sexual functioning, illness and death from HIV and other STD’s, boundary violations and clinicians’ well-being.
We stress that failing to learn skillful and relationship-centered interviewing about sexual issues can produce the following negative consequences for patient care:

**Avoidance of patients or not performing services**
- Not asking about risky sexual behaviors and counseling to minimize risk (a serious omission in this age of widespread HIV infection.)
- Not doing genital, breast and rectal examinations that detect cancer, STD’s and other conditions.

**Inability to manage advances or attractions from patients**
- Leads to tensions and confusion in encounters, preventing the development of a therapeutic relationship, even causing patients to terminate care prematurely.

**Increased risk of boundary confusion or violation**
- Unacknowledged or ambiguous sexual feelings can distort our perceptions or behaviors. Providers who are unaware or uncertain about their sexual feelings are more likely to engage in inappropriate behaviors that blur professional boundaries.

**Erosion of professional satisfaction and well-being**
- Denying or ignoring normal personal sexuality can limit the vitality and energy derived from work and relationships.

---

**BEHAVIOR CHECK LIST**

1. Provide appropriate rationale for sexual history
2. Ensure confidentiality
3. Ask concrete, specific questions
4. Ask about impact on patient’s life
5. Ask questions and respond non-judgmentally
6. Explore biopsychosocial context of illness e.g., relationships, stressful life events, etc.
7. Encourage expression of emotion and respond to emotion
8. Accept and validate patients’ feelings
9. Show nonverbal behavior that is congruent with verbal behavior

---

**LITERATURE REFERENCES**

4. deLahunta E, Tulsky A. Personal Exposure of Faculty and Medical Students to Family Violence. JAMA, 1996;275:1903-6.

loading..

loading..

Welcome to doc.com Module 19: Exploring Spirituality and Religious Beliefs

by Shimon Waldfogel, MD; Stuart R. Sprague, PhD
Rationale

Shimon Waldfogel, MD

The Patient's View
The Doctor's View
Shimon Waldfogel, MD

Questions for Reflection:

1. How might your spiritual/religious beliefs affect your ability to discuss spiritual/religious issues with patients?

2. In what circumstances do you believe it would be inappropriate to explore patients’ religious beliefs?

3. How would you respond to a patient who declines your advice because of a religious belief, such as a Jehovah’s Witness who refuses a needed blood transfusion?

4. How would you respond to patients who ask you to pray with them?

Check out the video example on the left and try answering the question below:

- What are your responses to the clinician and to the patient in this short movie?

Key Principles:

1. Religion and spirituality are important to many of your patients

2. When you explore the role of religion and spirituality in patients’ lives, this is usually helpful to them

3. When patients make meaning of their medical condition in religious terms, this may have positive as well as negative consequences for their well being

4. Clarifying patients’ religious interpretation of their suffering may help you offer additional support, including referral to an expert

5. Never impose your religious/spiritual beliefs on your patients, as this is a professional boundary violation
Learning goals:

At the conclusion of this module, you will be able to:

- Describe the rationale for exploring and supporting the role of religion and spirituality in patients’ lives
- Ask patients about the importance of religion and spirituality in their lives
- Explore whether patients’ religious beliefs give meaning and support to them in their experience of serious illness, suffering, and death
- Offer patients religious and spiritual supports such as referrals to clergy
- Describe possible professional boundary violations with respect to religious and spiritual matters

APPRECIATING PATIENTS’ RELIGION AND SPIRITUALITY

Religion and medicine have a common tradition of alleviating suffering; yet in modern times the religious/spiritual dimension of the person is little addressed in clinical training. Nearly three-quarters of Americans say that their approach to life is grounded in their religious beliefs. In clinical encounters, ignoring patients’ religious beliefs limits your ability to attend to their needs.

For millennia and across cultures and regions, religion and spirituality have had a special influence on people during times of personal crisis and suffering. It therefore seems likely to have an impact on health and response to disease. Just such an association has been demonstrated in numerous studies that have been reported in the medical, nursing, medical sociology and epidemiology literature. The inclusion of religious and spiritual problems in DSM IV further supports the importance of addressing this aspect of the person in the clinical setting. In this module we explore the role that religion and spirituality play in medical settings.

The United States is a highly religious nation with 94% of Americans professing a belief in God, 57% report praying daily, 42% attending religious services regularly. Nearly three-quarters of Americans say that their approach to life is grounded in their religious beliefs. (3) 82% of adults surveyed believe in the healing power of personal prayer and 77% believe that God sometimes intervenes to cure people who have a serious illness. Twenty-eight percent of the sample of 1004 adults believed in the ability of faith healers to make people well through their faith or personal touch. (4)

A substantial research literature now demonstrates that religious involvement has salutary effects on a broad range of mental and physical health outcomes, including mortality risk. (5-7) An early study of health related variables of 91,000 people in Washington County, Maryland, and found a decreased risk for Ischemic Heart Disease death, liver cirrhosis, emphysema, and suicide in people who regularly attended church. (8) In addition, studies have linked religious involvement with many behavioral health outcomes, including drinking, smoking, drug use, seatbelt use, sleep quality, and exercise. (9-11) Adolescent behavior studies find that higher levels of religious involvement are inversely related to alcohol and drug use, smoking, sexual activity, depressive symptoms and suicide risk. (12,13)
Researchers have explored a number of possible mechanisms to explain how religiousness may influence health and well-being. Examples have included support networks, coping processes, health related activities at religious institutions, and other psychosocial variables such as optimism and hopefulness, meaning, and forgiveness.(14-17) A meta-analysis of 147 studies concluded that there was a robust but modest inverse association between religiousness and depressive symptoms.(18) A meta-analysis of 49 studies of religious coping found that positive forms of religious coping were related to lower levels of depression, anxiety, and distress.(19) Similar findings come from reviews of studies of religious beliefs and coping among HIV-positive individuals. These studies have also found that spirituality and religion are positively related to immune system function.(20)

We include this module to help you explore these issues and develop your ability to explore and accept patients’ perspectives and decisions.

### DIALOGUES ABOUT RELIGIOUS AND SPIRITUAL ISSUES

Recognition is growing that the biopsychosocial model of health should include the spiritual dimension. (3-6) Inclusion would reinstate important therapeutic tools to clinicians’ repertoire, and enhance patients’ ability to cope with illness and suffering.

Attending to the spiritual dimension provides clinicians with a deeper understanding of patients and their needs. Religious beliefs impact on patients’ health and response to disease, and exert a special influence during times of personal crisis and suffering. Clinicians’ own religious or spiritual practices may impact upon their ability to function effectively in clinical practice.

The nature and depth of conversations about religious and spiritual issues will vary in accordance with the circumstances of clinical encounters, the time available, your role in the care of particular patients, patients’ views and responses, and your comfort with these topics. Conversation about advance directives or in the face of life threatening illness invites exploration of religion and spirituality in greater depth. Routine visits for minor medical problems may not call for as much attention to spiritual concerns.

### IMPLEMENTATION OF CONVERSATIONS

Four specific skills facilitate your exploration of the spiritual dimensions of health, well-being, illness and suffering. Use of these skills improves patients’ ability to cope with their medical circumstances and to enhance their well-being.

The framework already presented establishes the rationale for use of the skill sets discussed in this section. The skills parallel those discussed in the “Essential Elements” modules, with specific modifications related to the content area of religion and spirituality. The skill sets are as follows:

1. **non-judgmental exploration**
   Clinicians’ own religious (or anti-religious) beliefs can distort their perceptions of patients’ experience, as well as their interviews and relationships with patients. ([Example Video](#))

2. **Specific inquiry at times of suffering**
   Start with a general inquiry about patients’ illness experience and then ask how this
experience links to religious beliefs, how they interprets their suffering, and what role prayer or other practices play in efforts to cope.

3. **Demonstration of Understanding and Respect**
   Inviting patients to dialog about religion and spirituality at times of suffering is a complex process, and requires special attention to context, relationship and non-verbal signals.

4. **Suggesting / offering help**
   When patients trust you, you may direct them to helpful religious and spiritual resources in the community. (Example Video)

---

**Non-judgmental exploration**

Clinicians’ own religious (or anti-religious) beliefs can distort their perceptions of patients’ experience, as well as their conduct of interviews and relationships with patients. Develop your ability to explore and accept religious beliefs in a non-judgmental manner, independent from your own beliefs.

In parallel with inquiry about your patients’ family and social support systems, ask simple open-ended questions about their views on religious and spiritual issues, and whether religion and/or spirituality plays an important role in their life. The discussion of ‘Advance Directives’ (DocCom Module 32) can also be a useful context in which to address spiritual issues.

"How important is religion to you?"

"What role does spirituality play in your life?"

"Are you part of a religious community?" "What role does it play in your life?"

"Are there things you would like for me to know about your spiritual beliefs and how they have an impact on your health (or illness?)"

See Example Video on the next screen.

---

**Inquiry at times of suffering**

Start with a general inquiry about patients’ illness experience, and then ask how this experience links to their religious beliefs, how they interpret their suffering, and what role prayer or other practices plays in their efforts to cope.

Clinicians’ concerns about not seeming intrusive or insensitive, based on their own emotional response to severe suffering, may make it difficult for us to ask patients specific questions about their religious response to suffering. Practicing some potential inquiries and talking over situations with team members and colleagues can enable you to bring patients into conversation about these issues. These dialogues are not only supportive for their own sake, but they can also reveal possible new forms of support.

That asking specific questions of a patient who is suffering a life threatening condition might have
the effect of imposing an extra burden (the last thing a caring clinician would wish to do) should not deter you. However, questions need to be accompanied by good relationship skills (see 'Demonstrate Understanding and Respect' below). Remembering to pause for reflective silences is an invaluable aid to considerate dialogue. If patients demur from the discussion, you can move on, and if they seem offended you can offer a compassionate apology and listen with empathy to their concerns.

“This is such a difficult and painful time for you. How are you doing at this moment?”

“Can you tell me more about what it has been like?”

“Would prayer or meditation be helpful for you in these times?”

**Demonstrate Understanding and Respect**

When you invite patients to dialog about religion and spirituality at times of suffering, attend especially to your relationship skills and non-verbal signals.

When you address sensitive issues, whether in the context of life-threatening illness or acute or chronic suffering, show your acceptance of patients’ perspectives and demonstrate respect for them as persons. Your expression of understanding and respect must be both clear and genuine. Assure that your verbal expressions and your accompanying non-verbal gestures are consonant with each other (DocCom Modules 6 and 14).

[Check out the short video example about “demonstrate understanding” on the left.]

**Suggesting / offering help**

When you have confidence that patients feel understood and trust you, you can help them identify religious and spiritual resources within their community at times of confusion or loss.

The risk of seeming judgmental, insensitive or in some way inappropriate is particularly great when it comes to making suggestions or offering help around the religious and spiritual dimensions of patients’ lives. You should only attempt such offers or suggestions when your conversations make you confident that patients feel understood and respected in these areas. When and if patients signal their trust in your relationship, you can make suggestions such as meditation or prayer, or offer to enlist the help of an appropriate religious leader from the same faith background.
As an alternative, following exploration of religious and spiritual issues you can invite patients to make their own suggestions about ways to access greater spiritual support. This is often more effective than suggestions from clinicians. This kind of invitation can feel like a test or a burden to some patients, so attention to the skills of sharing information and reaching agreement (Modules 10 and 11) helps to discover strategies that work in patients’ best interest at this point in time.

Additional examples of resources you might explore with patients include the following:

- religious institutions’ outreach to medically ill individuals;
- community 12 step meetings;
- religious based counseling and prevention;
- early detection activities through religious organizations

Develop a list of clergy in the community who can serve as a cultural broker- someone who can put patients in touch with culturally appropriate resources.

"Can your religious beliefs or your spiritual community provide you some support at this time?"

“What do you know about resources that might help—have friends or neighbors mentioned help they received in times of stress?”

“In addition to the medications, I would like to help you find sources of moral or religious or spiritual support—if that makes sense to you?”

“Are you aware of counselling or support services available through your church?”

“I know of a church with many people from (Vietnam / Mexico)-perhaps the pastor there could put you in touch with ....”

See next screen for an example video.

AnnotatedVideo (not shown in print-out text)

PROFESSIONAL BOUNDARIES

Adjust your engagement with patients so that you respect your personal beliefs and sensibilities. Maintain a professional boundary – clinicians may be healers, but they are not spiritual leaders.

A crossover in the roles of clinicians and spiritual leaders is present in many cultures - after all, before the scientific era, societies’ healers were their priests or shamans. Patients have similar hopes whether they see a clinician or a spiritual leader, especially when their suffering is intense. They seek at least relief from suffering, and often hope for a miraculous cure. When you open the sensitive topics of religion and spirituality with patients, you sometimes tap into this complex territory.

If patients should ask you to pray with them, for example, your response is conditioned both by how fully you have explored the patients’ beliefs and by your own religious and spiritual experiences. If you affirm the value of prayer and you have explored patients’ beliefs and can genuinely respond positively, do so. You might also suggest that the patient pray while you listen quietly. If you do not feel comfortable with these options, respectfully decline and offer referral.

A gesture that would violate appropriate professional boundaries would be to spontaneously offer
to pray with patients because that is how you personally might handle the suffering. True professionalism means that you understand and respect the boundaries of clinician-patient relationships in the present era. Your engagement with patients should always be calibrated to match their needs to your sensibilities, and never to match your needs to their suffering, no matter how strong your personal commitment to a particular religion or spiritual practice (22,23).

**SUMMARY**

Most Americans say that religion is important to them. If you ignore this dimension, you limit your ability to attend to your patients’ needs.

Religious beliefs impact patients’ health and response to disease, and they exert a special influence during times of personal crisis and suffering. Empathic exploration and dialogue about religious and spiritual matters is an important therapeutic tool.

Clinicians who compassionately address religion and spirituality in their medical encounters can enhance patients’ ability to cope with illness. Helping to arrange referrals and consultations can provide additional support. In this module we provide both a rationale and a framework for conversations about religion and spirituality in medical settings, and we describe skills to implement such therapeutic conversations in a compassionate manner.

**BEHAVIOR SKILLS CHECKLIST**

At the conclusion of this module, you will be able to

1. bring up the topic of religion and spirituality
2. elicit patients’ perspectives on the importance of religion and spirituality in their lives and how their perspectives impact the present illness experience
3. elicit patients’ perspectives about their religious interpretation of their current suffering
4. elicit patients’ perspectives on the role of religious community
5. offer to help patients obtain additional spiritual help
6. include spiritual and religious considerations in development of treatment plans

**LITERATURE REFERENCES**


Welcome to DocCom Module 20:
The Family Interview

by Kathy Cole-Kelly, MS, MSW and Tom Campbell, MD

Credits:

Authors: Kathy Cole-Kelly, MD and Tom Campbell, MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patients: Heidi Fergusson, Roberta Weiss, Arnold Block
Clinicians on camera: Kathy Cole-Kelly, MS, MSW and Tom Campbell, MD
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A., Ernesto Matthias de Pina Walde (Assistant)
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.1 - 3/26/2012 Authors' edits implemented
3.0 - 1/17/2012 Enhanced with HTML5 code and MP4 videos
2.0 - 8/5/2009 Update to DocCom Version 4.0
1.0 - 8/23/2006

Video is loading..

Rationale

Kathy Cole-Kelly, MD
Questions for Reflection:

1. How confident are you that you can help a group of family members share information and feelings about complex medical situations? How confident are you that you can help them manage any conflicts that surface?

2. Is your own family more hierarchical or more democratic? Could all members participate in difficult conversations? Are there specific caregiver / caretaker roles for some members?

3. Reflect on how confident you are that you can respond with both an open mind and with empathy to family members who express health beliefs and behaviors that are quite different from your own?

Key Principles:

1. Including family members in routine medical encounters contributes to improved health outcomes. In planned family meetings, encouraging inclusive participation contributes to improved outcomes.

2. Effective interviewers always maintain patient confidentiality in family interviews.

3. Maintaining neutrality in family conflicts and empathically setting limits on interruptions and distractions facilitates success in family interviews. (exception: cases of family violence or abuse.)

4. Encouraging family members to share feelings and responding with empathy assists information exchange, finding common ground and adherence to plans.

Learning goals:

At the conclusion of this module, you will be able to:
demonstrate how to join with both patient and family,

demonstrate setting the agenda with the patient and family in the room,

demonstrate the most effective method of gathering information and managing a medical family interview,

identify methods of responding to family members’ emotions,

describe an effective method for establishing a plan with a family during a medical family interview.

INTRODUCTION

Families are the context within which most health problems and illnesses occur, and skillful family interviewing improves health outcomes.

Despite changing demographics of American families, most patients live with family members and are strongly influenced by family relationships. The family remains the most basic relational unit and intimate social environment in our society. As such, the family has a major influence on the physical and mental health of its members (1). Clinicians have the opportunity to anticipate and reduce the adverse effects of family stress and utilize the family as a resource in patient care.

The biopsychosocial model emphasizes interrelationships between biological, interpersonal, and social factors in health (2). It recognizes that the family is the primary source of health beliefs, health-related behaviors, stress, and emotional support.

Family interviewing skills are most often used during routine medical visits when another family member is present. Sometimes family skills will be used for planned family meetings, and these are usually in relation to end of life or serious illness events.

Family Influences on Health

A large body of research demonstrates that families powerfully influence physical health, including overall morbidity and mortality (1,2).

Numerous epidemiologic studies demonstrate that social support, particularly from the family, is associated with reduced mortality and morbidity (4). Family support improves outcomes from chronic medical illness, while family stresses such as loss of a spouse and divorce can negatively influence health outcomes.

Marriage has the strongest influence on physical health. Even after controlling for other factors, marital status affects overall mortality, mortality from specific illnesses (e.g. cancer and coronary disease) and morbidity (3,4). Married individuals are healthier than the widowed, who are in turn healthier than either divorced or never married individuals. Large studies show that bereavement or death of a spouse increases mortality, especially for men (4). Separation and divorce are also associated with increased mortality. The quality of marital relationships can influence the outcome of chronic medical illnesses, including coronary artery disease, congestive heart failure, end-stage renal disease and metastatic breast cancer (5,6,7).

Unlike patient centered interviewing, little empirical research exists on the relationship of patient and family satisfaction or health outcomes to specific family interviewing skills. However, studies
have examined the effectiveness and utility of family history taking, clinicians’ level of involvement with families, and family meetings (8). A recent meta-analysis of family interventions in a wide range of adult diseases demonstrated significant improvement in the physical and mental health of the patients as well as improvement in the health of key family members (9). This literature provides strong support for the importance of interviewing families in clinical practice (2).

THE SKILLS OF FAMILY INTERVIEWING

Families are always involved in major medical decisions and end-of-life discussions, and they sometimes participate in more routine medical encounters. Specific interview strategies will enhance the likelihood of beneficial medical outcomes.

Because families exert a tremendous influence on patient’s health, including family members in outpatient and inpatient settings is of critical importance. Ignoring or avoiding family members who would like to be present always has negative repercussions for the patient, and usually for the family and the clinician as well. Family interviews are common during discussion of end-of-life issues or around other major illness events, in the office or in the hospital. These situations are often the most important moments in patients’ lives, full of important decisions and conflicts. Family interviews also occur frequently when a patient’s family member attends a “routine” medical visit. A parent might accompany a child; an adult child accompany a parent; or a partner/spouse accompany the loved one.

Basic interview skills facilitate family interviews, but additional skills and strategies maximize both interview outcomes and health outcomes, particularly when important decisions must be made or conflicts managed and surmounted. Practicing the special skills that enhance family interviews builds confidence and the willingness to include family members when it is desired or when family members request inclusion. This module explores, describes and illustrates special skills for maximizing the benefit of family interviews.

Join with the Family.

Certain strategies help develop rapport and establish a positive relationship with each family member at the outset of an encounter.

- **With each family member, greet, shake hands and make a connection.**
  Greet each family member and learn each family member’s relationship to the patient. Make a simple connection with each and every family member - be mindful of reaching out beyond the family member who tends to take on the executive function in the family. Examples might sound like the following:

  “Oh, I heard you were flying in from California.”
  “I know you thado take off from work to be here..thanks.”

- **Rearrange the seating to establish the importance of the clinician’s relationship with the patient.**
  Often, a more dominating family member will take a seat adjacent to the clinician, with the patient placed on the other side of the family member. This creates a barrier between the patient and the clinician. Take the initiative to ask the family member to exchange seats with the patient, a symbolically important move. It establishes that the patient-‐clinician relationship is paramount and that family members cannot ‘unseat’ the patient.

- **Learn each family member’s relationship to the patient.**
  If uncertain about any person’s relationship to the patient, establish that relationship, so as
to understand the family member’s current or future role with the patient’s healthcare plan. Assumptions can often be incorrect - for example, when a man accompanies a mom and her infant. Misunderstandings can be painful and destructive, particularly when someone thinks that the clinician does not care who the players are.

"So, Estella, you are related to Virgina, how?"

- **Affirm the importance of each person’s contribution.**
  Set a positive tone by affirming the value of having each person present and involved in the family meeting. Explicitly acknowledge that family members’ presence in the room expresses their care and concern for the patient.

  "I’m so impressed that each of you cares enough about Hank to have put aside your other activities in order to attend this meeting."

- **Create a safe and supportive environment for all participants.**
  Take responsibility for leading the time together by stating the reason for the conversation. Let participants know that you will be not only the “scientific” expert, but also be attentive to supporting all participants in the conversation. Value everyone’s potential contributions by reminding everyone that you will do your best to keep the conversation on track and the tone positive. You can thus set a tone of respect and common concern.

  "We are here to explore the plans for Jane’s care. I expect you’ll have many questions and concerns. I’ll share my knowledge and the ideas that experts have discussed with me, I’ll try to keep the conversation on track and I’ll also work toward helping all of us be a team together by helping each of you to participate."

---

**Unique Circumstances**

Special circumstances alter the protocols for “joining” together.

- **Children:** Children often accompany family members for routine visits, and most children pick up much of a conversation even if they seem not to be paying attention. Use discretion in discussing topics that could be sensitive and negotiate with the patient about the child’s presence. In the case of patients who are children, arrange to have the have the parent close to the child while the clinician is talking directly to the patient; if a very young child, encourage the parent to hold the patient in her / his lap. See Module 21 about interviewing children.

  "We all need to be frank and open in our conversation, and if we approach very delicate subjects, I might ask whether you’d like to ask Tom and Jane to step outside with a puzzle or game for a few moments. How does that sound?"

- **Elderly or severely disabled patients:** The elderly patient definitely needs to be seated closest to the clinician. The most obvious reason is for the patient’s ability to hear the clinician. The “patient’s chair” is always the one closest to the clinician, and the actual patient, even in the case of dementia or other serious disability, should be in that chair. Many concerned adult children can inadvertently hamper the clinician’s ability to form a connection and establish rapport with the patient.

- **Interpreters- whether family member or professional.**
  Even though an interpreter may be doing most of the direct speaking to the clinician, the clinician should maintain eye contact with the patient and speak directly to him. Usually, the interpreter sits next to the clinician, although some patients prefer the interpreter to sit near them for comfort’s sake.
Family conflict.
All families have disagreements. Particularly if the medical situation is very complex or life-threatening, conflicts may become intense, and preferences difficult to negotiate. We present some strategies for working with disagreements below, but in the case of serious family conflict, experts recommend that the clinician separate family members and work with each member individually.

"The emotional temperature is getting very high here, and I’d like to suggest that I conduct some individual conversations as a way to get us on track. I’ll include everyone. Let me begin with Virginia, and ask others to step outside for a few minutes."

Family member abuse.
In situations where abuse of the patient is a possibility, the clinician must make space to interview the patient separately. See Module 28 for more details.

---

Set Agenda and Specify Goals

After initial relationship building, take the initiative to specify goals and outline an agenda for the family interview.

Clinicians should begin by stating their goals and their sense of the interview agenda, and then invite those present to state concerns, issues, other goals and their sense of agenda. Then, negotiate with the family as to what is realistic to address in this particular interview.

Working towards an unwieldy list of goals or towards goals that are too lofty will almost always sabotage the effectiveness of a family interview. Goals need to be linked to a health concern. A goal to "change how my mother acts when she is around us" is not an attainable one. However, the clinician might wonder whether "managing Jane’s pain better so that she is more comfortable (and less disruptive)" might begin a fruitful negotiation process about what can actually be done to improve Jane’s health.

In many situations, family members will have more global or complex goals for the patient that cannot be easily linked to the patient’s current medical situation. In such cases, a mental health referral to a family therapist is a helpful next step.

---

Gather Information

Respect and affirm each family member during information gathering by attending to each person, naming family resources and maintaining confidentiality.

- Gather information from each family member and elicit each person's perspective. Do not fail to elicit each person's perspective on the topic for the visit/meeting. Check with everyone about whether they have information about the situation that has not yet been stated. Leaving out any family member might result in missing data or views that could inform treatment decisions—often the quietest person's views prove to be insightful and facilitative for the family encounter. Particularly if family members' perspectives diverge, affirm each person's input. Inclusiveness minimizes later conflict and suggests that each person is welcome to participate in subsequent decision-making.

- Identify family resources. Family cohesiveness and ability to rally around the patient is strengthened when the clinician articulates family strengths and resources. Identify for everyone the supports and assets revealed as people gather and share thoughts.
"I'm impressed by how much everyone appears to care for each other in this family."
"It was not easy for all of you to get here, but you have all mobilized to support Tom."
"You seem like a thoughtful family, and you put family first - that will be a big help as we move forward."

- Do not breach confidentiality. Maintain strict confidentiality with the patient. If family members request information that the patient has not explicitly agreed to share, do not reveal it.

"How did Tom contract the hepatitis virus?"
"I'm not at liberty to share whatever information I have about this topic. Tom will decide what he wants to share with others."

---

**Set Limits during Information Gathering**

Information gathering drags interminably on unless the clinician has strategies for limiting distractions and setting limits. Without limit-setting the interview is unlikely to move to family agreement and task assignment.

- **Handle disruptions and distractions gently and firmly.**
  In many family interviews, one or more members interrupts others or asks distracting questions. The clinician must develop verbal and nonverbal skills that assist in minimizing time lost to distractions and also produce a helpful flow of information and views. Nonverbal gestures include gently raising the hand, like a benevolent traffic cop, or reaching over to gently touch the "noisy" person. Verbal statements, made with or without the gestures, might sound like the following:

  "John, we all value your views, but right now Sally has something she wishes to say."
  "It's crucial that I hear from everyone, and I'll be certain that you have the chance to share your thoughts, in a few moments."
  "This issue is complex, as we have discussed, and I need to hear from everyone in turn. We will not leave any stone unturned."

- **Set firm limits for persons who tend to monopolize.**
  Often, the most anxious family member tends to monopolize or interrupt. Assert leadership, while remaining empathic, and everyone will be reassured. Acknowledge the normality of anxiety in difficult and often unpredictable medical situations, and also remind the person who monopolizes that everyone's contribution has equal importance. State your appreciation that the person is trying to be helpful. Use the nonverbal “traffic cop” gestures (above). The PEARLS empathic statements (Module 6 - Partnership, stating the Emotion, Affirming the person, Respecting the attempt to help, Legitimizing the anxiety, and Supporting the person / family) all apply, and stating them along with the need for the person who monopolizes to give others a chance will be effective.

  "Gosh, it is normal for the unknowns in the situation to produce lots of worry for you; and I do value your thoughts. Right now, I need to hear from Jessica."
  "Thanks for your input. I know we are working toward the same goal of helping Adrian. I must ask you again to give me the space to hear from everyone."

- **Set similar limits if a family member seeks to speak for the patient.**
  When patients are able to speak for themselves, the person who "speaks for the patient" often is trying to be certain the clinician correctly understands the situation. Such people often are "controlling," because they have a strong idea about what facts are "correct" or
what would be the “best” next step. Employ empathic statements similar to those in the above paragraph in order to allay their fears that others do not fully understand.

"Thanks for the additional input. We will work together to fully understand the complexity of the situation so that we can design the best possible next steps. Because Kim is the patient, I want to be certain she speaks for herself about these issues- please hold off for a few minutes.... I’ll give everyone a chance to contribute.”

### Respond to Emotions

Sharing feelings and showing respect for feelings that people disclose promote successful family meetings.

- **Encourage family members to share feelings.**
  When family members discover that they share previously unspoken feelings, they become less isolated from one another. When they discover that the clinician understands the feelings and is comfortable receiving them, the family’s ability and motivation to think and act as a team, to set goals and cooperate with the clinician and with plans they establish is greatly enhanced. When feelings are mentioned, respond with empathy-use strategies discussed in Modules 6 and 13.

  “I hear that you are afraid James might die- this is a perfectly normal feeling in this situation.”

When feelings are not mentioned spontaneously, perhaps it is because some people do not readily share their feelings, or think that “sticking to the facts” is what they should do in medical situations. It is easy to let people know you value hearing about feelings, and that you encourage their expression.

  “I’d be interested to know how each of you is feeling about the new diagnosis for Suzanne? Please share your feelings with me- it will help us get over any rough patches as they arise.”

Ample evidence about family function supports the notion that giving each family member an outlet to express fears, confusion, irritation and reservations about a situation is comforting, helps people relax as much as possible in frightening circumstances, and builds cohesion. They feel understood and more confident in the clinician’s care. Finally, it helps them share both present and future concerns more freely.

- **Maintain an empathic stance with everyone.**
  Show every family member that you are a witness to their pain, difficulty or other emotion. Ignoring or avoiding or not responding to any one person diminishes everyone’s confidence in the clinician, and inhibits cohesion. Planning and adherence become more uncertain and less effective.

  Understandably, many clinicians find it difficult to strengthen their conviction that maintaining an empathic stance toward family members who seem to be contributing to the problem is facilitative. Once clinicians develop the confidence in their ability to show empathy despite reservations about the person in question, they discover that seeking to understand that person’s feelings often reveals hidden fears or frustration or anger. Not only is getting the feelings out and responding with empathy reassuring to that person and all family members, but it also builds cohesion. Sometimes it helps mend family rifts, and sometimes the “difficult” person becomes a strong ally in helping solve future problems.

  The important exception to this “rule” is when the clinician suspects that abuse or neglect is present. Family members should not be seen together until the team is satisfied that the
patient’s safety is ensured.

---

**Find Common Ground**

Clinicians who are effective in family interviews never "take sides" when conflict is present, and they reframe unique ideas to help find common ground.

- **Never "take sides" in conflict situations.** Sometimes a family member's feelings of fear or frustration (or another emotion) will surface as an accusation that someone is not doing something or doing too much of something. Maintain a position of neutrality when family members express their feelings in a manner that could develop into a conflict situation. A family member might lobby hard to get the clinician to "take my side," but falling into an alliance with one family member not only would make directing the conversation more difficult, but also would limit worthwhile outcomes. Remain a concerned listener:

  "Don't you agree that Matthew should stop pestered his sick brother about taking the medicine, Doctor?"
  "I hear your concern for your brother and understand your point, Kelley, but let's try to work out a plan together- no one has all the answers."

As in "empathic stance," above, if the patient's safety is at risk, protect the patient by helping organize a safe situation.

- **Find common ground for the family unit.** In any family visit or meeting, one key clinician goal should be to help all participants find common ground. Achieving this goal may be simple when everyone expresses concern for the well being of the patient. At times a participant may have an interest, a good idea or an individual concern that seems unique. Seek commonalities among various members' thoughts. Reframe an idea or concern as one worthy of joint concern for the entire family. This framing as the family's joint concern helps the family to work collaboratively towards what's best for the patient and the family.

  "I'm worried that Aunt Ida may not remember to take the medicine."
  "That is a good point, Albert, and I bet most everyone shares that concern? ....Let's make certain we plan the medication routine carefully."

---

**Reach Agreement and Close**

Bring family interviews to a successful conclusion by reviewing, summarizing, and agreeing on tasks. Assist dysfunctional families to achieve what is best for the family unit by referring them to a family therapist.

- **Begin with a review of the interview goals.** Review the reasons why the family came together for the meeting, and declare that the group has worked out a plan for meeting them. Remind everyone that few plans for complex situations are “perfect”, and that any needed adjustments can be made as the situation warrants.

  "Let's remind ourselves of the reasons we came together today. First, we agreed to explore whether everyone could lend a hand in helping Darius manage his ALS."
Summarize agreements, including next steps.
Summarize areas of agreement and plans for next steps. Check with each person in the room and secure their verbal or nonverbal assent. Ask if anyone – don’t forget to include the patient in this review - has residual or unspoken concerns or new ideas about next steps.

Get specific about tasks.
As the clinician summarizes agreements and next steps, the patient and some family members will often volunteer to help. Accept the offers, and ask who else can take on a task. Be very specific about who is doing what, and by when – write out the plans so that each participant does not have to count on remembering all the details.

"Tanya agreed to email everyone weekly about Jim’s progress. Larry will accompany Darius on every visit to the neurologist, and report results to Tanya.....”

Refer families that are not functioning well.
Clinicians who perceive dysfunction in a family should refer the family to a family therapist. The dysfunction might be that a family cannot unite around a common goal. The family dynamic may preclude healthy negotiation of roles and tasks. Perhaps conflicts may render supporting each other impossible. Start by acknowledging everyone’s suffering and the complexity of both the medical situation and its emotional impact. Then state that it is common that families facing this type of problem need assistance in finding common ground and supporting each other. Suggest a specific therapist that has helped others in similar situations. Acknowledge that all want the best for the patient and for each other, and that this therapist will be helpful in achieving this goal. Referral is always a delicate task- be frank, but succinct; be clear but empathic with each person.

"Looking at how hard this situation is hitting everyone, and how complex it is, I’m thinking that you all could use help is getting on the same track and supporting each other through this very difficult time. How does that sound to you?.... Nancy Deering, a trusted colleague who has helped many of my families at times like this could help you provide the best for each other. I’d like you to connect with her.”

Arrange a follow up meeting when appropriate.

AnnotatedVideo (not shown in print-out text)

RELEVANT BEHAVIORS

1. Greet each family member, connect with each one and establish his relationship to the patient.

2. Verbally create a safe environment.

3. Attend to special circumstances by acknowledging children, any disabled person, interpreters, and so on.

4. State interview goals and agenda, and check with participants.

5. Attend to information flow, including giving each person a voice, limiting excessive participation, and preserving confidentiality.
6. Encourage expression of feelings, acknowledge them, do not take sides in conflict, and seek common ground.

7. Summarize areas of agreement, establish specific tasks, and refer dysfunctional families.

LITERATURE REFERENCES

Credits:

Authors: Elizabeth A. Rider, MSW, MD, FAAP
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Patients: Six young patients from Dr. Rider’s practice
Clinician on camera: Elizabeth A. Rider, MSW, MD, FAAP
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: Ernesto Matthias de Pina Walde
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.0 - 1/17/2012 Enhanced with HTML5 code and MP4 videos
2.0 - 8/31/2009 Update to DocCom Version 4.0
1.0 - 12/11/2006

Video is loading...

Rationale
Elizabeth A. Rider, MSW, MD, FAAP

Video is loading...

The Patient's View

Video is loading...
Questions for Reflection:

1. When you last spent time around an infant, toddler, preschool, or school-age child, could you have engaged in age-appropriate play?

2. When last in a public place in the presence of a crying child, or one having a tantrum, what were your thoughts, reactions and feelings?

3. What would be easiest (hardest) for you about interacting with a school-age child with her mom in the room? Her dad?

4. What is the role of the parent in the pediatric encounter? What attitudes do you have about parents that might get in the way of working effectively with them?

5. What are your thoughts and reactions when in the presence of a seriously ill infant, toddler, preschool or school-age child?

6. Were you or a sibling seriously ill at a young age, and what feelings do you recall about that experience?

7. What childhood interactions with clinicians do you remember, and what are your feelings about them? How might you use these experiences (positive or negative) to learn how to effectively engage with children and their families?

Key Principles:

1. Building and sustaining relationships with children and their families is the cornerstone for competent pediatric care.

2. Infants, toddlers, preschool and school-age children have different world views and react differently, requiring clinicians to vary their greetings and interactions accordingly.

3. Playing with children is essential for good pediatric care; and clinicians play differently with infants, toddlers, preschool and school-age children.

4. Direct communication between clinician and child improves relationships, satisfaction, adherence, and health outcomes.

5. The foundation of quality pediatric care is the clinicians’ ability to skillfully open the interview, understand the child’s and family’s perspective, build relationship, share information and reach agreement.

Learning goals:
At the conclusion of this module, you will be able to:

- Describe the rationale for including children in the interview and demonstrate skills for engaging them.
- Describe the typical illness concepts of preschool children and school-age children.
- Describe techniques for communicating with children of varying ages including the use of play and rapport-building strategies.
- Elicit the child’s and parents’ perspectives on the illness / problems as well as their understanding of treatment plans.
- Invite and elicit feelings of parents and children; acknowledge and accept those emotions.
- Describe ways to show empathy in the pediatric interview
- Share diagnostic and treatment information gently, with respect and compassion; avoid jargon

INTRODUCTION

Pediatric interactions are complicated, routinely involve the doctor–parent–child triad and other family members, and are influenced by the cognitive and developmental stage of the child and changing family roles. The pediatric encounter encompasses not only medical problems, but also psychosocial and developmental issues.

"When I cough my brain shakes." – 3-year-old Ethan describing his headache

"No doctor! No doctor!" – 2-year-old Ryan, initially refusing to be examined (1)

"It sounds like she swallowed a whistle." – Mother of 1-year-old infant

Communicating with children and their families is complex, and differs in many ways from communicating with an adult who is capable of making health care decisions.

- Children are constantly changing, and their perspective varies by developmental stage, including their cognitive, social, and emotional development.
- The changing needs of both children and family members require that clinicians be flexible enough to modulate their interview and physical examination strategies according to developmental stage.
- Pediatric interactions routinely involve more than one family member. Parent(s) or guardian, and often the patient’s sibling(s) are present.
- The doctor-patient relationship expands to become the doctor-parent-child relationship. The interaction dynamics of this triadic communication are particularly challenging when child and parent have different needs.
The pediatric interview encompasses not only medical concerns, but also psychosocial and developmental concerns. More and more children are seen for behavioral and developmental problems, especially in primary care.(2)


The Doctor–Parent–Child Relationship

The child’s communication role deserves special attention. Studies show that direct communication between clinician and child contributes to improved relationship, satisfaction with care, treatment adherence, and better health outcomes.(3,4)

“I’m so scared, my eyes are making tears.”
– 4-year-old Jonathan, worried about getting shots.

Health professionals formerly relied on parents for information about their child’s health. Children understand more about concepts of health and illness than previously thought, can provide unique and valuable information about themselves, and, when able, should be involved in decisions about their own health care.(5,6)

Check out the video example:
As in any clinical interview you will see relationship building and other communication skill competencies carried out in conjunction with history taking and other interview tasks. The interviews, physical examinations and their scrolled list of skill labels selectively focus on communication / relationship skills rather than the complete medical interview or complete physical examination.

Different communication needs of parent and child pose an important challenge to relationship-centered care in pediatrics. Even when clinicians support facilitation of child participation, parents may promote a passive child role that leads to sub-optimal treatment. Clinicians can be explicit about partnering with parents and teach them the rationale for the child’s active participation. At the same time, clinicians need to address parents’ needs and call on parents’ expertise and knowledge of their child.

Clinicians can collaborate with parents to help children have a voice in medical encounters. After all, both parents and clinicians want the best for the child.

Strategies that engage the child’s participation

Engaging the child directly and conducting meaningful conversations with the child activate the child’s effective participation.
• Address the child by name
• Invite the child to state the problem
  "Emma, why have you come to see me today?"

Check out the video example that role-models taking the history from a 2 year old child.

• Encourage the child to participate in the conversation
  • Verbally: direct questions to the child
    
    Alex, has anything else been bothering you? How about your ears?

    Kelly, how long have you had a runny nose?

    Alice, can you put your finger right where it hurts?

  • Non-verbally: eye-contact, nodding, smiling at child

• Give advice and explain treatment plans to the child in words they can understand
• Provide parents with a role model for subsequent interactions by conversing directly with the child

  4-year-old Jonathan:  "I’m so scared, my eyes are making tears."

  Clinician:  "What are you scared about?"

  Jonathan:  "Getting a shot."

  Clinician:  "I understand. It’s okay to be scared and to cry. Lots of kids are scared of shots and don’t like shots. All kids who are 4 years old have to have 2 shots. The shots help keep you well."

  Jonathan’s mother:  "Remember when Molly [Jonathan’s friend] got her 4 year old shots?"

  Jonathan:  "I don’t want a shot!"

  Clinician:  "I know you don’t want a shot. We’ll do it very quickly and then you can pick out a sticker. You can sit in your Mom’s lap."

  Clinician:  "Do you have a dog?"
  "Do you know how dogs pant when they’re hot?"
  "Okay, your job is to pant like a dog. Let’s practice. I’ll tell you when."

  While you give the shot, it sometimes helps to distract the child— "Pant like a dog!"
  "We’re done! Would you like to pick out a sticker?"
Skills and Strategies that Contribute to Parent and Child Satisfaction Enhancing satisfaction

Parents highly value clinicians who attend to both their and their child’s feelings and concerns (8) who seek to understand their perspective, and who utilize better communication skills. Clinician attitudes of curiosity, humility, respect and reflective practice (14) are likely mediators of parent satisfaction.

Parents who believe their child’s clinician is friendly, understands their concerns, and has better communication skills, are more satisfied.(9,10)

Greater parent satisfaction is positively associated with:

- more active communication between clinician and child
- adequate attention to parental concerns regarding the child’s illness (11)
- parents’ perceptions of the clinicians’ ability to provide information, interpersonal sensitivity, and partnership-building

In the setting of a life-limiting condition of their child, Davies (12) found that sensitive pediatricians demonstrated the ability to understand the parents’ perspective, were humanistic, had good technical skills, and sought to understand the parents’ life world.

Check out the video example where the history taking with the mother of a 5 month old child is demonstrated.

Parents who changed pediatricians because of dissatisfaction perceived the pediatrician to be poorer at communicating effectively.(13)

Browning (14) notes that self-awareness and reflective practice are central to clinicians’ compassionate communication with children and their families. He recommends that pediatricians develop a capacity for reflection, and come to value curiosity, humility, and respect for parents’ expertise that will help them better understand the child and family.

The child’s experiences with health care may form a life-long attitude toward clinicians and the health care system overall. Pediatricians have the opportunity to improve children’s health behaviors.

Developmental Stages of Children Child development

Communication with children (and parents) improves if clinicians understand and respect the differences reflected in the stages of child development.

"Why do we have necks to keep our heads up?“ -
Children constantly change and their perspective varies by developmental stage, including aspects related to their cognitive, social, and emotional development. The clinician affirms and supports good parenting, and acknowledges and teaches about developmental milestones and child development.

The table below presents information about children’s cognitive development and their concepts of illness at different developmental stages.

**Table 1. Children’s cognitive development and concepts of illness at different ages.**

<table>
<thead>
<tr>
<th></th>
<th>Preschool children (3 – 5 years)</th>
<th>School-aged children (6 – 12 years)</th>
<th>Adolescents (≥ 13 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive development</strong></td>
<td>• Magical thinking; circular reasoning</td>
<td>• Emergence of clear differentiation between self and others</td>
<td>• Capable of cognitive problem solving and decision-making</td>
</tr>
<tr>
<td></td>
<td>• Sees 1 or 2 aspects at a time; may ignore the whole of the situation</td>
<td>• Begins to think relationally and to generalize</td>
<td>• Ability to think abstractly and hypothetically</td>
</tr>
<tr>
<td></td>
<td>• Doesn’t differentiate well between self and outside world; lives in the immediate environment</td>
<td>• Begins to integrate variables in causal relationships, and to reverse these relationships</td>
<td>• Uses generalization to fill in gaps in knowledge</td>
</tr>
<tr>
<td><strong>Child’s concept of the cause of illness</strong></td>
<td>• Doesn’t spontaneously conceptualize the internal parts of the body</td>
<td>• Can distinguish what is internal and external to self</td>
<td>• Integrates multiple factors in understanding illness; imagines alternative possibilities</td>
</tr>
<tr>
<td></td>
<td>• Illness results from wrongdoing; medical procedures are seen as a punishment</td>
<td>• Cause of illness is a person, object, or action external to the child: “you get a cold from not wearing a hat”; “you breathe too much air in your nose.”</td>
<td>• Cause of illness lies in internal physiologic organ or process; may have additional psychological cause</td>
</tr>
<tr>
<td></td>
<td>• Illness is caused by external concrete phenomenon: contagion, magic, “from the sun”, “from outside”</td>
<td></td>
<td>• Understands illness as internal systems that dysfunction and cause external symptoms: “a virus gets into the bloodstream and causes a cold.”</td>
</tr>
</tbody>
</table>
Approaches to Children at Different Stages

Different developmental stages bring about different needs for both the child and family members, and require varied interviewing, examination, and counseling approaches. (18) Placement of the child in the room, play strategies, relationship building strategies, and history taking are important variables.

Table 2. Approaches to the pediatric interview with children at different developmental stages

<table>
<thead>
<tr>
<th></th>
<th>Infants (0 – 15 months)</th>
<th>Toddlers (15 months – 2 years)</th>
<th>Preschool children (3 – 5 years)</th>
<th>School-aged children (6 – 12 years)</th>
<th>Adolescents (≥ 13 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location of child during interview</td>
<td>• Parent’s lap or arms</td>
<td>• Parent’s lap or arms</td>
<td>• Freely moving about room</td>
<td>• Exam table</td>
<td>• Exam table</td>
</tr>
<tr>
<td>Relationship building strategies</td>
<td>• Talk with child</td>
<td>• Talk with child</td>
<td>• Talk with child</td>
<td>• Talk with child</td>
<td>• Talk with adolescent</td>
</tr>
<tr>
<td>Play strategies</td>
<td>• Respond to baby’s sounds; smile</td>
<td>• Pretend-play; guessing games; tell stories; hide and find things.</td>
<td>• Make-believe; hide and seek; counting &amp; number games; mimic animals; hand puppets; read</td>
<td>• Make-believe games; improvise; jokes &amp; riddles; magic tricks; guessing games; hobbies; sports</td>
<td>• Discuss issues, school, activities; relationships with peers; sports; role-taking in clubs, groups</td>
</tr>
<tr>
<td>Can obtain some history from child</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

COMMUNICATION SKILLS IN THE PEDIATRIC ENCOUNTER

The quality of the relationship with the child and family affects all aspects of patient care – the diagnostic process, treatment decisions, adherence with treatment, and patient and clinician satisfaction. Despite the extraordinary scientific and technological advances in modern medicine, the core skills and *sine qua non* for the delivery of quality health care remain those
of maintaining good relationships and skillfully communicating.

Create and sustain a relationship with the patient and family

A therapeutic and communicative relationship with the patient is the cornerstone of competent medical care. Building and sustaining relationships with children and their family members remains an ongoing task within all encounters.

Components that underlie an effective clinician-parent-child relationship include: attention to the child as a person, attention to the child’s and family’s values, motivation, and thoughts, and attention to the way each family member experiences the child’s illness. Other important building blocks of effective relationship that will be explored in subsequent sections include respect, positive regard, empathy, listening skills, nonverbal communication, and understanding the role of play with children. The relationship is, after all, a shared experience.

Frameworks for describing skills and competencies

Use specific relationship-centered skills or competencies to create therapeutic relationships with patients and families. These include: being “present” and listening attentively, opening the interview; learning about the patient as a person; empathy and compassion; non-verbal activity; and play with children. Clinicians who reflect on their own thoughts and feelings, and are mindful of what they bring to the encounter, enhance the effectiveness of their skills.

Several useful frameworks and descriptions of interpersonal and communication skills and relationship-centered care exist. Three useful models include:

1. The Kalamazoo Consensus Statement (19) identifies seven essential communication competencies, with sub-competencies for each, applicable to most medical encounters and adaptable across specialties, settings, and health issues. This Statement is the underlying structure for DocCom. (for more info see LINK 1 on the bottom of this page)

2. Rider and Keefer,(20) with an international group of medical education leaders, expanded the ACGME interpersonal and communication skills competencies, added 20 sub-competencies and created a teaching toolbox. Their teaching toolbox connects these competencies to teaching strategies at each level of medical education. Check the second LINK on the bottom of this page to see the list of skills in this model that pertain to the ability to create and sustain a relationship that is therapeutic for children and supportive of their families.
Similarly, the Ambulatory Pediatrics Association, with help from 300 pediatric experts, developed guidelines for education in pediatric residencies.(21) including suggestions for building relationships with patients and families. See Link 3 on the bottom for further info.

**LINK 1:** The Kalamazoo Consensus Statement “essential” competencies were developed by a group of North American experts in clinician-patient communication including DocCom authors: Tom Campbell, Kathy Cole-Kelly, Michael Goldstein, Geoff Gordon, Dennis Novack, Elizabeth Rider, and Robert Smith. The competencies include: building the patient–doctor relationship; opening the discussion; gathering information; understanding the patient’s perspective; sharing information; reaching agreement on problems and plans; and providing closure. These competencies are presented in Modules 06 – 12 of DocCom.

**LINK 2 :** The following skills comprise the ability to create and sustain a relationship that is therapeutic for patients and supportive of their families*:

1. Be “present,” paying attention to the patient, caring for the patient, and working collaboratively and from strengths.
2. Accept and explore the patient’s feelings, including negative feelings.
3. Provide a sustainable relationship that allows for repair when mistakes are made, and includes authenticity, honesty, admission of, and sorrow for, mistakes.
4. Communicate with the patient’s family honestly and supportively. The clinician-patient relationship in pediatrics is imbedded in and extends to the family.

To see the entire list of competencies and the teaching toolbox, you can access the article.


**LINK 3:** *The Ambulatory Pediatric Association Educational Guidelines for Pediatric Residency* contains a section on Core Communication Skills. It suggests building relationships with patients and families with sensitivity, tact, and empathy by doing the following*:

1. Greet patients and families and show interest in them as individuals.
2. Demonstrate empathy and compassion with patients and families.
3. Use words that show care and concern throughout the interview.
4. Use tone, pace, eye contact and posture to show care and concern.
5. Be aware that ideas, feelings, and values of both the clinician and patient influence the relationship.
6. Understand that building relationships with a patient is an ongoing task within and across encounters.
7. Respond to patients and families non-judgmentally and non-defensively.
8. Respect and be aware of patients’ privacy and confidentiality.

The Ambulatory Pediatric Association communication skills guidelines were developed by Elizabeth Rider and others, and were drawn, in part, from the Kalamazoo Consensus Statement framework.

Rapport is a primary component of building a relationship with patients, and the clinician begins building rapport from the opening moments. Rapport requires mutual interest and respect between the clinician, child and parent.

In pediatrics, a variety of individuals may accompany the patient – e.g., siblings, one or both parents, grandparents, other relatives, guardian, or the nanny. To establish a positive context for the interview, open the interview with an inclusive introduction and greeting, acknowledge everyone in the room, use their names, and find out how they are related to the patient. Greet and welcome the child. Even with infants, the clinician can smile and interact with the infant for several seconds. This also gives the clinician a moment to assess the patient.

Clinician to infant:
“Look at you! You’re getting so big.”

Clinician to preschooler:
“Hi! How are you today?”

Welcome the child, even if initially resistant, as we see with 2-year-old Ryan
“No doctor! No doctor!”
exclaims my next patient, his small hands pressed tightly over his ears, a determined scowl on his face. Ryan is 2 years old. I smile at him and say
“Hi.”
“No doctor!”
he replies. After talking with his mother and letting him get used to me, I approach him slowly. . . . “[p. 414] (1)

Address and acknowledge siblings in the room. Siblings can be disruptive if they feel displaced by a new baby or another sibling, so your early invitation to engage can have an important calming effect on the entire encounter–siblings may behave better for the rest of the interview (though this isn’t always the case). Your invitation and leadership also engages and assists the parents.

Clinician to sibling:
“Did you bring your baby brother today? Does he cry and make lots of noise?”
“Sometimes babies do funny things!”

---

**Learn about the patient and family**

Getting to know the patient and parent as individuals creates a connection that will increase their willingness to work with you on both simple and complex issues. It develops a context within which to understand your patient’s problems, and improves your ability to successfully manage the child’s care.

*Effective communication requires an understanding of the patient in her/his world.*

Make a social, non-medical comment to put the patient at ease at the beginning of the visit:
**Clinician to preshooler:**

“Did you just have a birthday? How old are you? What did you have on your birthday cake?” (Questions about birthdays are particularly effective with preschoolers.)
“What’s your favorite thing at preschool, not counting lunch or recess?”
“Who lives in your house?”

**Clinician to school aged child:**

“What grade are you in now?”
“I see you’ve brought a book with you. What are you reading?”
“Do you play sports?”

**Find out who are the significant people in the patient’s life?**

To child:

“Who lives in your house?”
“Who takes care of you?”
“Tell me about your friends.”
“Who can you talk to if you’re worried about something?”

To parent:

“Does anyone help you out at home?”

**What is important to the patient?**

To child:

“Do you have any questions?”
“What do you like to do with your friends?”
“What things make you happy? sad? mad?”
“Is there anything you are worried about?”
“What are some things you are good at?”

To parent:

“Do you have any questions or concerns for today?”
“Any changes at home or in your life since we last met?”
“Does Maria talk with you about what’s going on at school?”

**What contributes to the patient’s and family’s health and well-being?**

To child:

“What do you like to do with your mom? your dad? your sister or brother?”
To parent:

"What sorts of things do you do together as a family?"
"What are your child care arrangements? How are they working?"
"Do you get time for yourself?"

Sick children affect the entire family. If a child has been up all night crying from an earache, the parents are likely to be exhausted and worried.

Clinician to parent:

"You must have been up all night too."
"I imagine you are tired."

Note: Many risks to children’s health and development are preventable, and comprehensive health promotion and prevention are major aspects of pediatric practice. The Bright Futures national health promotion initiative provides a practical, developmental approach for primary health care for children and adolescents. Bright Futures materials cover many topics including: health supervision guidelines; recommendations on routine health screening, anticipatory guidance and immunizations; and tools to help families and clinicians support healthy social and emotional development, monitor psychosocial development, and to identify early behavioral and emotional problems. Questions to address with families are provided. For more information, access the Bright Futures website. URL: http://www.brightfutures.org/.

Empathy and compassion

Clinicians should show empathy and compassion in every encounter with patients.(22)

The ability to convey empathy is an innate human quality, expressed in nurturing of children, family, friends, ill persons, and so on. The ability may be stifled or hidden by the demands of learning the science of medicine and other procedural skills of doctoring. Rekindling the ability or fostering it in a professional environment requires specific intention to do so. The effort can be aided by learning a set of skills(23). The ability to convey empathy in infinitely diverse and complex medical interview situations requires a mindful approach to encounters, listening to feedback and continuing practice. (Modules 2, 6,13)

"Empathy is the clinician’s ability to understand the patient’s situation, perspective, and feelings and to communicate that understanding to the patient,” (page 221)(24) such that the patient feels understood.(25)

Empathy is different than sympathy. Sympathy occurs when the clinician listens to the patient’s story from the clinician’s point of view. Empathy occurs when the clinician listens to the patient’s story from the patient’s point of view.

Check out the video example about the examination of a 9 month old child - with the whole family there and included...
Compassion is a powerful component of the clinician-patient relationship. Compassion means ‘with passion’, with caring, with the need to ease the patient’s suffering. It is consciousness of the patient’s distress together with a desire to alleviate that distress. Compassion takes seriously the reality of other persons, their inner lives, emotions, experience of illness, and external circumstances.

- Empathy helps the child and family to feel validated, respected, and understood.
- Studies suggest an association between the clinician’s caring and empathy, and the effectiveness and appropriateness of care as well as patient satisfaction (26).
- Conveying empathy effectively increases diagnostic accuracy and patient adherence, yet remains time-efficient (27,28).
- Empathy increases clinician satisfaction (29).

**Conveying Empathy and Compassion**

Conveying empathy requires that the clinician receives or perceives emotions and clues to emotions as a first step and, as a second step, responds to them in ways that the patient and family can perceive.

Children express their emotions in varied ways. When they do not express them directly by, crying or having a temper tantrum, or by clinging, they may offer us clues. Much of empathic communication is subtle, and subject to cultural differences, particularly in its non-verbal elements. Because of this subtlety, empathy may be lost because clinicians may be preoccupied with the cognitive work of organizing very complex data about diagnosis and treatment, while patients are preoccupied with confusion, worry, politeness or other social rules for medical encounters.

The words we use with patients help us to pick up on the patient’s clues and to elicit and respond to their emotions. What we say may promote empathic discussion, or miss it, or actually terminate it. Clinicians can attend to connectedness and relationship, and remain empathic in spite of the obstacles by exercising basic empathic skills that include the following (30):

- **Recognize when the child or parent has emotions that are present but not directly expressed in words.** The child may hide behind the examination table, or cling to a parent. A parent may appear stone-faced or distracted, look away or down, in some way break the engagement of the conversation, or say something not related to the current conversation.
- **Invite exploration of unexpressed feelings.** With a younger child, one might comment: "Sometimes kids feel scared when they come to the doctor and have to have a shot."
- With older children, we can ask: "Are you worried?" "How are you doing right now?" "What are you feeling scared about?"
- With the parent, we can ask: "What are you most concerned about?" or note: "You look skeptical."
- **Explicitly acknowledge and accept feelings.** Showing the child and parent that you are trying to understand helps them to feel understood. "You seem worried by all this, which is pretty common in this situation."
- **Accept children’s expressions of upset or grief.** Crying usually brings relief and can be helpful to the child. Don’t overreact to tears or other upset actions; do not tell children not to cry; do not try to distract children from their feelings. Ignore temper tantrums.

**Additional Strategies that facilitate conveying empathy (31)**
Possessing a toolbox of strategies to promote empathic communication promotes your efficiency and enhances patient satisfaction.

Questions:

"Can you tell me more?"
"Is there anything else?"
"What has this been like for you?"
"Were you scared?"

Reflections

of the content and checking in about what the patient is saying:

"What I am hearing is . . . Do I have it right?"
"I want to make sure I’m understanding what you are telling me."
"It sounds like you think . . ." “Did I leave anything out?”
"Are you worried about having a shot?"

Responses:

"That sounds really hard."
"It seems like that might feel . . ."
"You must feel proud about that. That’s great!"
"You were really brave. Good for you!"
"I can see that that is bothering you."
"It’s okay to cry. No one likes to have a shot."

Use effective listening skills

Clinicians demonstrate effective listening by reflecting, summarizing and checking whatever seems odd or unusual in the context, so that the patient appreciates the attempts to understand, and can correct or add information that completes the picture.

"I suspect that the most basic and powerful way to connect to another person is to listen. Just listen. Perhaps the most important thing we ever give each other is our attention. And especially if it’s given from the heart. . . . We connect through listening.” (p. 143)(32)

Check out the video example: as in any clinical interview you will see relationship building and other communication skill competencies carried out in conjunction with history taking and other interview tasks. The interviews, physical examinations and their scrolled list of skill labels selectively focus on communication / relationship skills rather than the complete medical interview or complete physical examination.

Active listening skills enable the clinician to hear and address the concerns of children and their families. Effective listening skills facilitate relationship20, and help patients understand that better care derives from collaboration between clinician and patient. Listening inattentively or without mindfulness can lead to diagnostic and treatment decisions that are incorrect at best and dangerous at worst.
Shortly after 9/11, I saw an Arab American father and his 5-year-old daughter in our office. She had a viral rash, and her father repeatedly asked if she had chicken pox, even after I explained why she did not. Listening to his persistent and anxious questions, and understanding them as a clue, I asked,

"Are you concerned about anything else?"

"Does she have smallpox?" the father asked.

Only after he verbalized this underlying concern was I able to effectively provide reassurance, and he expressed his gratitude and relief.

**Non-verbal communication**

Mindful nonverbal communication helps develop an environment of trust, support, and comfort. “Nonverbal” includes body language as well as tone, pace and pitch of speaking. Nonverbal cues of inattention or distraction are more powerful than the words you say. Congruence between words, voice characteristics and body language is essential for effective communication.

To focus the interview on the patient as well as the illness, and to show interest in the patient as a person, the clinician must demonstrate, non-verbally, that what the patient has to say is important. Use non-verbal cues such as nodding, pausing, maintaining eye contact, and posture to show attentiveness and concern. (M14)

![Check out the video example](image-url)

**Check out the video example:** the interviews, physical examinations and their scrolled list of skill labels selectively focus on communication / relationship skills rather than the complete medical interview or complete physical examination.

Strategies for nonverbal communication that promote connectedness and cooperation:

- Establish eye contact with the infant and child from across the room. Chat with the parents while the child becomes more comfortable with your presence.
- Sit down, and respect the child’s personal distance. If your face is too close to an infant’s face, she may look away and cry. Toddlers do not want anyone unfamiliar in their personal space. A good strategy is to look away when you are close (e.g., listening to heart and lungs). Approach school-aged children calmly and respectfully.
- Adults appear large to small children. Make yourself appear less threatening by sitting at the child’s eye level or having the child sit on a high examination table with the parent nearby.
- Adapt your own pace, tone and posture in response to the child and parent. Tone and pace of speech sometimes communicate feelings more effectively than the words themselves.

Sometimes young children are frightened about being examined. I ask the parent to hold the child in their lap, and I sit at the child’s eye level. When I listen to the child’s lungs, for example, I slow my rate of speech and may whisper,"Do you have Elmo back here? Or Big Bird? . . . “ A young child often calms to a gentle, quiet approach.
Avoid interruptions of patient visits. This includes interruptions from phone calls and beepers. Do not try to read the chart or use the computer while listening or talking with the child and family.

**Children and play**

Play is an integral component of healthy child development and learning. An effective strategy for communicating with young children is through the metaphor of play.

Through play, children explore the world, gain understanding of themselves and others and communicate with peers and adults. As you observe young children play, you will see family-related themes, action plans for helping and healing, and for avoiding threats. Children use play to learn about the world and to explore their abilities to cope with its complexities. Children’s play becomes increasingly more varied and complex as they grow. (click here to see Table 2 on Developmental Stages of Children)

When examining young children, creating a playful atmosphere helps the pediatrician complete necessary tasks and adds enjoyment for both the child and the clinician.

"No doctor! No doctor!"

exclaims my next patient, his small hands pressed tightly over his ears, a determined scowl on his face. Ryan is 2 years old. I smile at him and say

"Hi."

"No doctor!" he replies. . . . (p. 414) (1)

The interview proceeds playfully with the pediatrician asking:

"Where is your heart? Is it here?"
"Do you have birthday cake in your tummy?"
"Let's check!"
"Do you have bunny rabbits in your ears?"
"Which ear should we check first?"

The examination concludes:

When he realizes our time is up, he lags, pulling on his mother’s arm so he can remain in the examination room.

"More doctor! More doctor!"

he exclaims. (p. 414; for a description of the full examination see reference (1))

**Understand the child’s and parent’s perspective**

*Understanding the patient’s perspective* includes understanding the child’s and family’s individual concerns, beliefs, and expectations, and respecting their cultural and ethnic beliefs, practices, and language. (20) The child’s perspective depends upon her or his developmental stage. (M9)

"When I cough my brain shakes." –
3-year-old Ethan describing his headache

"It feels like bees are in there." –
7-year-old Eliza describing her ear ache

"Are deer ticks carnivores?" –
4-year-old Michael with questions after being brought to the pediatrician for a tick bite

Check out the video example: The 8 year old girl shows insight and concern.

How does the child and family experience the child’s illness? What are the child’s ideas about their illness? Listen to the patient's or family’s story, elicit their understanding of the causes of illness and possible treatments, and identify their major concerns. Ask about life events, circumstances, and other people that might affect health. Elicit expectations about illness and treatment.

“What do you think has caused the problem?”
“What concerns you the most about your child’s illness?”

Children reveal clues to their concerns and perspective through their questions and comments.

“Does your heart go on vacation?”
7-year-old Carlos asked during his yearly checkup. After further discussion it becomes clear that Carlos is pondering the concept of death.(33)

David, age 10, was hit in the leg with a baseball. During the visit, his mother expressed her concerns about his future fertility, and was reassured to learn that David was unharmed. Following a discussion of puberty, hormones, and the changes that occur as bodies grow, the following dialogue ensued between David and his pediatrician:

As we wrap up the visit, I ask him,

"Do you have any more questions?"
"No," he replies, "I figured it out."
"What did you figure out?" I ask.
"Girls attract hormones," he concludes. (p.792)(34)

You can also ask the child and parent to articulate their emotions (e.g., "You seem worried; is that right?") and respond explicitly to their expressed ideas and feelings.

After a three-year-old well-child visit, Sarah’s mother shares that Sarah has seemed anxious and worried since the 9/11 terrorist attacks. We talk further. I kneel down to Sarah’s eye level and tell her

“your mommy is safe, your daddy is safe, and you are safe”.

She looks at me with big, attentive eyes and I know I have connected. With solemn seriousness, she slowly pulls her lollipop out of her mouth and says, with great emphasis,

“And my kitty cat.”
Sharing information

Because clinicians contend with life and death, the power and impact of words is magnified, and patients and worried parents can be easily frightened by careless word choices, especially about prognosis.

Share diagnostic and treatment information gently and use words that are easy for the patient to understand. Intersperse the telling of information with asking about understanding and impact. Patients highly value these gestures of respect, dignity and consideration.

Check out the video example where the physical exam on a 5 month old child is demonstrated.

Clinicians who understand a child’s developmental and cognitive perspective and use this knowledge when sharing information, provide better communication, better relationship and better care.

3-year-old Victoria, her infant brother, and her parents came to the office several weeks after Victoria’s 20-month-old brother, Sean, had died of a congenital disease. It was a busy weekend day with patients scheduled every 10 minutes. While I examined her infant brother, Victoria hid near the examination table and occasionally peeked out. Her parents and I talked about Sean’s death and how they were coping. Victoria’s mother commented that Victoria repeatedly asked, “Where is Sean?” and that she had become increasingly clingy and would not let her parents out of her sight. After further discussion about young children’s view of death, and their cognitive inability to see it as permanent, I noted, “I think two things are going on that are common reactions 3 year olds have when someone has died.” “Victoria may fear that, because Sean disappeared, either parent could do the same.” I explained the need to repeatedly and concretely reassure Victoria that, even though Sean went away, her mother and father, and her baby brother were not going to go away, even when she was bigger. We also discussed the fact that 3 year olds have an egocentric view of the world and tend to think that things happen because of them—for example, Sean’s death. “You can reassure her that it’s not her fault that Sean died, that it happened because he was very sick with a sickness she and her baby brother and her parents did not have and could never get.” During this discussion, I also spoke directly to Victoria, modeling the conversation her parents could have with her. Victoria emerged from her hiding place, first moving behind her mother, then moving more freely around the examination room, and finally initiating conversation with me.

Partner with patient and family
The clinician-patient relationship is a partnership. When working with children, create an atmosphere of mutuality and respect by inviting active patient and family collaboration throughout the encounter, with particular attention to involving them in decision-making.

To partner with patients (19,20):

- Invite them to help establish the agenda for encounters (Module 5, 7.)
- Check for mutual understanding of information about diagnosis and treatment. (Module 10)
- Collaborate in negotiation about diagnostic and treatment options and the establishment of mutually acceptable diagnostic and treatment plans
- Include the child (as appropriate) and family in choices and decisions to the extent they desire. (Module 11, 17)

Adopt a relationship-centered perspective. Effective communication between clinician, child and family is always a two-way, reciprocal process that involves flexibility in interaction and relationship development between human beings, rather than simply the collection of facts and establishment of diagnosis and treatment.

**NOTE:** Children’s Emotional Health Link (CEHL) is designed to provide clinician training in psychosocial pediatrics, to improve clinician-patient communication and to help doctors and nurses become more skillful in assessing emotional problems in children. CEHL uses a “strength-based” rather than pathology-based approach. The website [http://www.cehl.org](http://www.cehl.org) contains thoughtful articles for parents, pediatricians, and other health professionals as they work together to improve the emotional health of children.

**SUMMARY**

Building and sustaining relationships with children and their family members is an ongoing task that includes a set of skills that can be improved with knowledge and practice. Communication between clinician, child and family involves conversation and relationship between human beings rather than simply the exchange of facts. A therapeutic and communicative relationship with the patient and family is the cornerstone of competent pediatric care.

Children are not small adults.

They present their chief complaint in unique ways stating:

“I have bees in my ears.”
“When I cough, my brain shakes.”

And they ask questions like:

“Do teeth bleed?”
“Can you check my mom to see if she’s going to have another baby?”

The pediatric interview is influenced by the cognitive and developmental state of the child and changing family roles. Children see the world differently at different developmental stages and ages. Younger children communicate through the metaphor of play. Your history and examination will be different with children of different ages.

Working with parents and families is an important component of pediatric care. The pediatric interview routinely involves the doctor–parent–child triad and other family members. The pediatric interview encompasses not only medical concerns; more and more children are seen for behavioral and developmental problems, especially in primary care.
We can have meaningful conversations with children. Studies show that direct communication between clinician and child contributes to improved relationships, satisfaction with care, and better health outcomes.

**ALL VIDEOS**

**Timothy:** 8 days

**Carl:** 5 months

**Margret:** 9 months

**Shanty:** 2 years

**Max:** 5 years

**Sarah:** 8 years

Please click any of the hyperlinks to start the respective video

**RELEVANT BEHAVIORS**

- Greet and welcome the child and family members, introduce yourself, address and acknowledge siblings and other family members, and show interest in them as individuals
- Make eye contact with those present, and continue eye contact when addressing the child and family members
- Encourage the child to participate in the conversation and share information with the child
using words the child can understand (when age appropriate)

- Actively elicit and respond to feelings of the child and family members
- Affirm and support (good) parenting
- Position yourself at the child’s eye level and respect the child’s personal distance.
- Adapt pace, tone and posture in response to child and family members
- Use play and create a playful atmosphere
- Acknowledge developmental milestones
- Elicit and respond to the child’s and parent’s concerns and perspectives
- Encourage the patient and family to participate in decision-making about diagnosis and treatment to the extent they desire

LITERATURE REFERENCES

15. Rider EA. Does your heart go on vacation? (A narrative on listening and talking with pediatric

17. Perrin, E.: Sticks and stones may break my bones...Reasoning about illness causality and body functioning in children who have a chronic illness. *Pediatrics* 1991;88:608-619.


30. Suchman AL, Markakis K, Beckman HB, Frankel R. A model of empathic communication in the medical interview. *JAMA* 1997;277:678-682.


33. Rider EA. Does your heart go on vacation? (A narrative on listening and talking with pediatric patients). *BMJ* 2004;328:890. URL: [http://bmj.bmjjournals.com/cgi/content/full/328/7444/890](http://bmj.bmjjournals.com/cgi/content/full/328/7444/890)

34. Rider EA. Privates (a narrative on talking with children and their parents about difficult topics) *BMJ* 2006;332:792. URL: [http://bmj.bmjjournals.com/cgi/content/full/332/7544/792](http://bmj.bmjjournals.com/cgi/content/full/332/7544/792)

35. Rider EA. It's because they didn't know our names. (A narrative on the pediatric care of children in the time of terrorism). *Arch Pediatr Adolesc Med* 2002;156: 531. URL: [http://archpedi.ama-assn.org/cgi/content/extract/156/6/531](http://archpedi.ama-assn.org/cgi/content/extract/156/6/531)

loading..
Questions for Reflection:

1. What experiences and behaviors do you remember from your adolescence that might help you empathize with adolescent patients?

2. Looking back, can you recall some clinicians’ characteristics that helped you decide to trust them?

3. Might some of your current attitudes about adolescents interfere with your building trusting relationships with them?

4. Why did most of us engage in one or more risky behaviors as adolescents and young adults?

5. What factors make it simpler or harder for teens to stop risky behaviors; or to adopt health-promoting behaviors?

6. What factors give caregivers a unique opportunity to help teens adopt less risky behaviors?

7. What is most complex or intimidating for you about collaborating jointly with teens and their parents?

Key Principles:

1. A specific focus of adolescent medical interviews is to explore and reduce risky behaviors.

2. Every teen has some strengths, competencies, and inherent resilience.
3. Healthcare professionals who explicitly recognize and appreciate teens' dilemmas and strengths build a zone of safety that facilitates effective conversations about behavior change.

4. Collaborative dialog that explores linkages between stress and risk-behavior sets the stage for consideration of behavior change.

5. Partnering with parents and teens in brainstorming alternative ways to adapt to stress is a prerequisite to guiding patients towards more healthy behaviors.

6. In the special case of medically unexplained symptoms (somatization), clinicians can assist through compassionate conversation that explores connections between stress, brain and body chemistry and symptoms.

---

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe the health impact of exploring the psychosocial and environmental context of adolescent behaviors.
- Utilize trust-building communication strategies to promote open, honest and mutually respectful collaborative communication with adolescent patients.
- Establish a collaborative dialog with teens as active participants in the health promoting process (do not make them passive recipients of lectures they are likely to reject!)
- Encourage teens to mediate change in risk-behavior by building on their strengths.
- Compassionately explore how stress drives risk-behaviors and how the mind-body connection generates somatic symptoms.
- Partner with patients in brainstorming and utilizing alternative strategies to manage their stress.

---

**WHAT MAKES ADOLESCENT MEDICINE UNIQUE?**

Fully 80% of what kills adolescents is preventable. Risk-behaviors are teens' responses to stress and are amenable to counseling. The problem of unexplained somatic symptoms is common and distressing, and also usually a response to stress. This module outlines strategies to address risk-behaviors and somatization through respectful exploration, using a strength-based counseling paradigm.

Take even a perfunctory glimpse at morbidity and mortality statistics, and you will understand that if we are to save adolescent lives and preserve health, we must do more than evaluate their presenting physical complaints. Few adolescents visit clinicians' offices with the intention of discussing the risky behaviors that lead to 80% of deaths in the 14-24 age group. Furthermore, addressing key subjects such as alcohol, suicide, sexuality and safety is a daunting task for providers.
Advances in understanding young peoples’ stressors and anxieties as well as consideration of clinicians’ role in adolescent healthcare have prompted changes in both the goals of medical interviews and in strategies for successful interventions. The traditional “at-risk” questions about sex, drugs, anxiety, etc. position the clinician as adversary rather than advocate, because every young person anticipates a "lecture" to follow. Not only does such an approach fail to inspire honest answers, thoughtful consideration, or behavior change, but also many youth feel offended, judged or shamed by it, thus reducing the open-mindedness required to explore risks or initiate behavior change.

As medical professionals who care for adolescents, we can position ourselves as advocates. As we discover what these young people are doing right in their lives, we can better help them develop confidence and a sense of competency. We need to move beyond telling them what not to do, and instead reinforce healthy behaviors in which they are already engaging and respectfully guide them to explore new capabilities that are based on their pre-existing strengths.

In this module, we discuss concrete relationship-centered approaches to facilitating respectful, honest and safe communication with teens. We organize the adolescent visit into three phases, Setting the Stage, Eliciting the Medical and Psychosocial History, and Strength-Based Counseling. We emphasize that adolescent stress is the central driver for many risk behaviors, and for somatization. We present tools for eliciting and exploring sources of stress, for coordinating a strength-based approach to advising and counseling, with example dialogues and conversations.

**SETTING THE STAGE**

Enable honest communication by explaining to teens why you will ask personal questions, what you will do with confidential information, and what benefits teens derive from choosing to share honestly with you. Spending 3-4 minutes on stage-setting builds trust, shortens subsequent encounters and smooths the way if clarifications become necessary later on.

Adolescents, like adults, are hesitant to disclose personal information unless they trust and respect the questioner. Typically they ask the following questions: (1) Why is the clinician asking me personal questions? (2) What if I don't want to discuss this information now? (3) Is it worth my time sharing private information; can this person even help me if I ever need it? (4) What will he or she do with the answers; will I be judged or have my business spread around? Prepare teens for the visit and facilitate honest dialogue throughout the visit by telling the youth what to expect, using a four-step strategy we call "Setting the Stage."

"Setting the Stage" should not take longer than 2-3 minutes and should be done at the beginning of every new patient encounter and when a patient turns 11 or 12. Taking 2-3 minutes in a visit limited to 10-15 minutes is substantial. However, spending the time up front saves time later and also improves relationships and the quality of information about sensitive topics. Failing to do so generates uncertainty and confusion and wastes time if a teen seems unwilling to open up.

**Stage-Setting: Why "personal questions"?**

Teens respond positively to explanations that demonstrate respect.

Help patients understand why you will ask questions about their “private” life. Studies show that teens are more likely to share personal information when clinicians thoughtfully explain how these data relate to their healthcare (Ginsburg, 1997). Consider beginning the encounter by saying,
"I’m a doctor; my job is to save lives and help patients stay healthy. I worry about many things like sore throats and sprained ankles, but also about things like violence, drugs, stress, and depression. Do you agree that doctors should worry about these things?"

Stage-Setting: Talk about autonomy and honesty

 Teens value honesty and freedom to choose what to say.

 Particularly in the situation of meeting the clinician for the first time, youth seldom wish to discuss everything going on in their lives. Show respect for their autonomy by acknowledging that they can choose what to discuss, and also acknowledge the importance of honest disclosure.

 "You can ask me anything and I’ll be honest. I’d like to talk with you about those things I just mentioned, and I need for you to be honest with me. I’ll work with you to help you explore ways to stay healthy and safe, right now and whenever you need me in the future.”
 "Just because I ask you a question, though, doesn’t mean you have to answer it. I’d rather you say: ‘I don’t want to talk about that today’ than give me an answer that is not true.”

 "Remember, I don’t read minds. If you tell me something that isn’t truthful, I won’t know. But I also won’t be able to help you or answer your questions about a subject you may really want to talk about."

Stage-Setting: Talk about benefits of trust

 Teens value trusting relationships.

 Whether patients will benefit from sharing private information is a concern for everyone. This is a big issue for teens, but they seldom have a conscious awareness of it and so explicit reassurance about the benefits of a relationship based on mutual trust is helpful. They may have little knowledge about how a clinician can be helpful now and in the future, particularly if they do not perceive current needs.

 Assure the teen that the current and future benefits of trusting you with personal information include both enabling you to answer difficult questions truthfully and enabling you to provide help for complex situations and dilemmas in an unbiased fashion.

 "My job is to help my patients and I, along with the team I work with, know how to do this. Of course it is hard to open up to someone you don’t know well, but I want you to know that I am here to help you in any way I can.

Stage-Setting: Talk about confidentiality

 Teens value privacy and confidentiality – especially with regard to parents.

 The most critical barrier to open communication for youth is the worry about how much doctors can tell their parents. Similarly, youth are also concerned about confidentiality within the office,
as some office staff live in their community (Ginsburg, 1997). Few adolescents are aware that state laws protect their right to privacy.

Youth benefit from guidance in understanding the nuances of doctor-patient confidentiality (Ford, 1997; Ford 2001; English 2007). Be specific about what confidentiality means, and under what circumstances it may need to be broken. Avoid using the standard phrase, “I will keep your information secret (or confidential) unless I am worried you will hurt yourself, hurt someone else, or if an adult is hurting you.” Using the word “hurt” (instead of “kill”, below) leads adolescents to think their clinician will report smoking, drugs, and sex, all of which they expect doctors think “hurt” them. Furthermore, using “secret” or “confidential” could backfire because teens attach shame to the word “secret”, and misconstrue “confidential” as “confidence”. Instead, use the word “privacy”, and when discussing “confidentiality”, state its limits clearly. Communicate with youth that in the case of a crisis when confidentiality should be broken, they will be involved in strategizing how to best manage the safety concern.

“The most important thing for you to know is that what you talk about with your doctors in considered private information. I know you are worried about who I may tell if you tell me something that is going on in your life. I have to keep your information private; I cannot tell anybody without your permission; not your parents or other people in the office unless they are the doctors or nurses involved in your care. There are laws that protect privacy. This is called 'confidentiality' and doctors have to uphold it for every single patient."

"There are three situations when I have to break this promise: if your life were in danger because (1) you were going to kill yourself or (2) kill someone else or (3) if someone was abusing you. In these cases, I have to get help right away because your life is in danger. Does this make sense?"

**Stage-Setting: Repeat key words; remind**

Teens value reassurance that their clinicians will do what they have promised.

Before asking about sensitive matters later in the interview, repetition of key words such as “personal questions”, "choice in answering”, “honesty”, or “private information” provides additional reassurance and safety. Furthermore, in follow-up visits a brief mention of these key words recreates the atmosphere of trust and enables honest communication.

"Jasmine, I want to remind you about some important things I stressed to you last time we met. You always have a choice in answering my questions when I ask you about personal matters and how your life is going. I hope you can be honest with me, because I want to help you in any way I can, and I am not here to judge you. Remember that whatever we talk about is "confidential" and that means I have to keep your information private and I cannot talk about you with anyone, including your parents, our office staff or other doctors or nurses, unless the they are also helping take care of you. Do you remember the three situations I cannot uphold this trust? If you are thinking of killing yourself, killing another person or if someone is abusing you. If any of those things are going on, I have to get you help right away."

**Video is loading**

Oana Tomescu MD, PhD, is setting the stage in this movie
Set the Stage with Parents

Provide anticipatory guidance to parents by partnering with them. Build trusting relationships by acknowledging their unique and changing role and by emphasizing the balance between confidentiality / privacy and safety.

Parents often accompany adolescents, and they carry their adult and parental concerns regarding risks and safety. Teens are seldom willing to participate openly in discussions about sex, substances, stress and so on in the presence of a parent. Thus, clinicians should balance time that includes parents against solo time with patients. In case of future crisis, team-based interventions can be more easily coordinated if the clinician has developed a partnership with both teen and parent (Ford, 2009). Facilitate the parent-partnering process with explanations and reassurances similar to those used in building trust with patients.

Check out the video example about emphasizing the role of the parents.

When asked to leave the room, many parents will feel left out of discussing the issues about which they are most concerned (i.e. violence, safety, sex, and drugs). Coordinating and balancing private and joint time can be difficult, especially if there are conflicts between parent and teen. To the teen, reinforce your commitment to confidentiality and to providing a safe place where the teen can come for help, and to the parent, outline a team-oriented plan in case of crisis.

Here are examples of what you can say to the parent and teen:

**Directly to the child:**

*Now, my job is to help you, but if you were really in trouble, who could help you the most?*

Listen and learn from the child’s response, then redirect if necessary, with the goal of having the teen mention their primary caregiver.

*Yes, I think that your mom/dad/caregiver can help you the most, too. Now, I meant what I said before: I promise your strict privacy, but don’t be mad at me if I think you might be headed for trouble and I suggest we work together to figure out the best way to get your parent(s) involved. But don’t worry I won’t do it without your permission unless your life is in danger.*

**Directly to the parent:**

*If we do come to you, I’d like for us to work together as a team to keep your child safe. But I’d like us to agree now that if something comes up in our visits, your son/daughter would not be punished. Wonderful things can happen here if young people know this is a place they can come for help without fearing they will be punished.*
Parents: Explain that age changes visit focus

Acknowledge that the pediatric to adolescent healthcare transition signifies a change in parent role.

The change is not only from being the primary medical decision maker to being “co-manager” of decisions, but also from being the primary supplier of medical information to someone who jointly explores medical information. Naturally, the teen’s role changes as well, and adolescents need assistance in becoming active participants as well as more involved in management decisions. Direct most questions to patients, but also encourage parents to be careful listeners and to supply additional information when needed.

Mrs. Brown, I want you to understand that another part of my job is to get Jasmine ready to see doctors all on her own. I am going to ask her for most of the information I’ll need, so she can practice speaking for herself with doctors. Please let her respond first, but listen carefully, we’ll probably need you to teach her information she does not yet know.

So Jasmine, if you don’t know the answers to some questions pay attention to what your mom says; you’ll need to know this information soon when you begin seeing doctors by yourself.

Parents: Explain need to talk alone

Teen patients need to learn to speak for themselves with their doctors.

One clinician task at this life stage is to help younger patients practice becoming more independent. This simple but explicit explanation usually helps parents be more supportive about the clinician’s request to spend time alone with their teenager.

Mrs. Brown, once we’ve covered the medical information and discussed any concerns that you have, I’d like to speak to Jasmine by herself. She is old enough to be examined in private and needs to gain comfort talking to doctors alone.

Before that happens though, I want to make sure we address all your concerns. And as I said before, if Jasmine’s life is in danger, we all need to work together to help her to stay healthy and alive. Is that OK?

Parents: Explain confidentiality and safety

Restate the importance to teens’ health outcomes that derives from a commitment to balancing confidentiality and safety.

Reassure parents that they will not be excluded if their teen is having significant health, psychological, or safety issues, but also restate your commitment to confidentiality.

Jasmine, I meant what I said before about protecting your medical and health information; and I also meant it that my primary goal is to help keep you safe and healthy.

So I want you to know that if I am ever worried that you are heading for trouble, I am
going be very honest with you about trying to get your parents involved to help. I promise, though, to always work with you to get the help you need. OK?

AFTER SETTING THE STAGE

Preventive interventions as well as diagnostic and treatment efforts will fail unless clinicians employ additional tools to build on “stage-setting.” This is particularly true with youth who show discomfort or participate with reluctance.

“Setting the stage” begins building trust because it addresses teens’ concerns up front, provides them with resources in case of crisis, and allows them to evaluate clinicians’ style, attitudes and professionalism. Of course, some youth will require additional interventions before they develop comfort in communicating honestly. Substantial research underscores the importance of provider interpersonal style in building trust with adolescent patients (Malus, 1987; Resnick, 1980; Schuster, 1996). Some patients feel intimidated or vulnerable because of the power dynamic inherent in the doctor-patient relationship, others because of discomfort with unfamiliar places, people or “authority” figures. Some youth use toughness and “attitude” as a defensive posture, testing every adult until the adult proves trustworthy. Studies indicate that youth respond to and seek providers who are honest, respectful, caring, non-judgmental, consistent, and professional (Ginsburg, 2002a; Ginsburg, 1995, Ulager, 2005).

As an interview progresses beyond the initial stage setting, additional communication strategies can help clinicians with patients who hesitate to grant their trust. Relationship building with youth utilizes the tools of empathy – attentive listening and observation of nonverbal cues accompanied by empathic verbal and non verbal responding. In addition to facilitating data-gathering and shared decision making, empathy tools help achieve a deeper understanding of patients as whole persons, as well as their illness and life perspective (Stewart, 2001; Street, 2007; Maguire, 2002). Patient-centered communication improves both satisfaction and overall health status (Mead 2002; Wanzer, 2004; Street 2009) and probably reduces diagnostic testing and referrals (Stewart, 2000).

A simple acknowledgement of the discomfort inherent in the power differential begins to lower communication barriers. Additional empathic interventions such as showing interest in understanding the patient by reflecting what is heard (or seen), normalizing situations, making partnering statements and summarizing aspects of the interview demonstrate to the patient that the provider is fully present in the conversation, and increase the likelihood of open and honest communication (DocCom Modules 5, 6, 13); Robertson, 2005; Laidlaw 2007; Smith 2012).

The body language of clinician and patient conveys positive and negative messages that powerfully improve or dampen communication. Shaking hands warmly, sitting at eye level, making eye contact and leaning slightly forward convey the intent to listen actively (DocCom Module 14, Maguire, 2002; Robertson, 2005). Let the patient know that note-taking or typing is necessary, but avoid it when discussing personal information. A teen who avoids eye contact, mumbles or gives one-word responses is struggling with something (DocCom Module 14). Clinicians who respectfully and non-judgmentally acknowledge such cues use reflection, legitimizing, partnering and attentive listening to demonstrate their caring attitude, their professional stance and their trustworthiness.

See Table 3 for example communication strategies.

THE ADOLESCENT MEDICAL HISTORY

When obtaining the teen’s medical history, use patient-centered strategies and involve
parents. This reinforces your trust-building efforts during stage setting and prepares participants for the more delicate psychosocial history to follow.

After stage setting, gather medical history. Youth, like many adults, often adopt a step-wise “testing” format when deciding whether to trust a clinician: they divulge a bit of information and judge the adult’s reaction. If the clinician responds without judgment, keeps their confidence, and demonstrates a caring attitude (Ulager, 2005), teens reveal more, and do so in larger increments. Consistency in spoken words, body language, and eye contact demonstrates to youths that it is safe to be open and honest. Research shows that effectively building the relationship results in better information gathering and improved health outcomes (DocCom Module 6).

Use a patient-centered interview style (DocCom Module 5) to show patients that you can suspend judgment while attentively listening. Medical questions are perceived as less intrusive by patients, and help reinforce your prior work of building a safe and trustworthy relationship. If parents are present, include them incrementally by first querying patients and then asking parents to contribute additional details. The incremental strategy has multiple benefits: it provides anticipatory guidance for youths’ future visits without their parents; it gives parents an opportunity to teach children; it allows clinicians to observe family interactions and it strengthens the team-oriented approach to caring for teens. It extends the zone of safety, no matter how you sequence the gathering of complete information. After the medical history, guide the conversation towards the psychosocial realm, and use the same incremental strategy.

I’m going to ask your mom these questions too. I want you to listen to her answers because it is really important that you know your own and your family’s medical history. Soon you are going to be going to doctors by yourself and you’ll need to be able to provide this information.

Check out the video example about the medical history.

PSYCHOSOCIAL HISTORY: KEYSTONE OF THE ADOLESCENT INTERVIEW

Use the SSHADESS tool to elicit the psychosocial history. SSHADESS is a dual-purpose screening strategy that enables clinicians to learn about teens’ strengths and to explore teens’ current risk-behaviors.

Preventable and modifiable risk behaviors are the major determinants of youth mortality and morbidity. Thus, a careful psychosocial history must be a major interview focus, and it must not only provide information about sex, drugs, tobacco and alcohol, but also highlight teens’ strengths, capabilities and current coping strategies. Their strengths and capabilities can then be enlisted to help youth avoid or modify risky behaviors. We recommend using the SSHADESS tool, which encompasses questions about self-described Strengths, School, Home, Activities, Drugs, Emotions (depression and suicidality in particular), Sexuality and Safety. SSHADESS emphasizes Strengths and Safety, encompasses Emotions more broadly than Depression, and is an expansion of
“HEADDS” (Clark, 1995).

With parents present, ask the less intrusive questions about **Strengths, School, Activities**, and friends. Involve parents incrementally and address any parental concerns in a way that is supportive of the teen’s right to privacy. Before asking the more personal questions about **Drugs, Emotions, Sexuality** and **Safety**, ask parents to step out. The video and Table 4 present suggestions for making this request.

[Image: Check out the video example about asking parents to leave the room.]

We again emphasize the delicate nature of relationships with teens and the continual need for reassurances about safety, confidentiality and trust. After parents leave, re-establish confidentiality and follow the general guidelines below to assure successful completion of the **SSHADESS**’s more sensitive questions. The guidelines, which might be referred to as an “outward-in” approach, give insight into the teen’s surroundings, alert the patient to what is coming next, and also allow the clinician to make adjustments and give reassurances that sustain the relationship, if needed.

- Tailor the inquiry for each patient and community
- Begin each inquiry with a focus on peers in school and the neighborhood
- Move next to the patient's friends and lastly to the patient
- When the teen gives a worrisome answer, avoid any reaction and finish the "general" screen before pursuing follow up inquiry about worrisome data.
- Most importantly, withhold any "counseling" input until the SSHADESS inquiry is completed.

Premature counseling disrupts patient disclosure and limits clinician understanding of psychosocial context and situation. Similarly, both “positive” and "negative" clinician reactions may dissuade teens from disclosing worrisome behaviors, as they may not want to "disappoint" the doctor. Maintain special attention to nonverbal signals of approval or disapproval, because nonverbal communications carry disproportionate strength in this circumstance. Listening to youths' disclosures of risk behaviors is difficult and particularly so when the youth's background is different from the clinician's. Become aware of your own biases, expectations and emotions, so that you do not send mixed messages to teen patients. Relationship-building is a central goal, so do not push young persons further than they are ready to go. Finally, keep in mind that having as therapeutic a conversation as possible is usually more important than obtaining every detail.

**SSHADESS: DETAILS**

Below we list the SSHADESS components. Then, in each of the pages that follow, we expand and comment on each aspect of the screen. We show example dialogue that is likely to engage patients in a positive fashion.

- **Strengths**
- **School**
SSHADESS: Self-described Strengths

A good transition to the SSHADESS inquiry could be something like,

"Mary, I know about your medical history now, but I also want to know more about you. Why don’t you tell me about yourself? How would you describe yourself?"

Some teens will be at a loss and cannot find words to give the clinician information about their self-image. In this case ask,

"How would your friends describe you?"

Ask specifically and directly about strengths, because this information paves the way for a strength-based approach to subsequent behavioral counseling:

"What is your biggest strength?"

If parents are present, include them in this conversation.

SSHADESS: School

School performance may reflect the teen’s overall well-being, and a decline in school performance is often predictive of other problems. Additionally, youth without dreams of a future may put themselves at greater risk. Conversely, commitment to schoolwork and to academic achievement are important protective factors (Sege, 1999; Dekovik, 1999).

Questions about school might include:

"How is school going for you?"
"What are your favorite subjects?"
"Are there any you do not like?"

"What are your dreams for your future?"

If parents are present, include them in this conversation.

SSHADESS: Home
Knowing who lives in the home provides information about the youth’s general environment. Many teenagers have a tense relationship with their parents, but a more critical fact is to determine whether relationships are reaching crisis proportions. Ask about home life with the parent present, and also ask again when parents have left the room. Discovery of problems may enable you to guide families towards family-based interventions that promote more thoughtful communication and discipline techniques.

Questions about family might include:

"How are things at home?"
"Who lives at home?"
"How are things going with your parents/siblings?"

If parents are present, include them in this conversation.

---

**SSHADESS: Activities**

Peer relationships are exceptionally important to teenagers. Knowing what a patient’s friends are doing offers a clue about negative pressures the patient may encounter. Youth with few friends and “nothing to do” are more likely to fill time with risky behaviors, and conversely, constructive use of free time in youth programs, or after-school activities is protective for youth (Lerner, 2002; Gestsdottir, 2007; Mahoney, 2000; Fredericks, 2006).

Questions about activities might include:

"Tell me about your friends?"
"What kinds of things do you do together?"
"What do you do after school?"

If parents are present, include them in this conversation, and then invite them to leave the room.

---

**Check out the video example** about asking parents to leave the room.

---

**SSHADESS: Drug Use / Substance Use**

Mind altering substances contribute sharply to morbidity and mortality from injuries and violence, to school failure and depression and to the acquisition of sexually transmitted diseases.

Ask general questions about the school and neighborhood first, then about the patient:
"Are there a lot of drugs in your school or neighborhood?" "What about alcohol or cigarettes?"
"Have your friends ever tried drugs, alcohol or cigarettes?"
"Have you ever tried?"

If the teen has tried substances and especially if the teen opens up about chronic use, elucidate the reasons behind the drug use so as to better understand the context before engaging in a counseling discussion.

Say something like:

"Thank you for being honest with me. Can you tell me more about how often you are using X?"
"Some people use X for fun, while others use it to escape some other stress in their lives. Do you have a sense of what makes you use X?"

(for additional suggestions, see the Adolescent Stress section).

**SSHADESS: Emotions / Depression**

Few teens admit to feeling “depressed” or “anxious,” sometimes because of concern about stigma associated with “mental illness,” sometimes because they do not yet know what the terms mean. But screening teens for depression and anxiety is critical, and all teens understand feeling “stressed-out.” Most of them can be prompted to discuss the causes of stress and the coping strategies (either positive or negative) they have utilized. Elucidation of who the teen turns to for help gives insight into a teen’s sources of support, and the unhappy youth with no one to talk to is at tremendous risk. Suicide is the third highest cause of mortality among adolescents (CDC, 2006), so inquiry about suicide is paramount. In the weeks or months preceding a suicide attempt, many teens seek care for “routine” or vague health concern when unable to speak about a “hidden agenda” about how badly they feel (Hawton, 1982; Slap, 1989; Capelli, 1995). If any response is worrisome, carry out a more comprehensive screen, and consider referral to mental health services (DocCom Module 27).

Questions about emotions, stress and suicide might include:

"Are you generally happy; how is life going for you?"
"When you have a bad day, what do you do?"
"Do you have anyone to talk to when you feel stressed out, or when you have a bad day?"
"Do things ever get so bad that you’ve thought about killing yourself?"

**SSHADESS: Sexuality**

Approach the subject of sexuality with no preconceptions of level of sexual activity or of sexual orientation (Ginsburg, 2002b; Marshal, 2008; Garofalo, 1999; Remafedi, 1998)). Some teenagers resent adult assumptions that they have had sex. Additionally, many youth are in turmoil about sexual activity, orientation and identity and do not have a responsible adult in whom they can confide. Keep pronouns gender-neutral until teens disclose the gender of their partner.

Open-ended and non-gender specific ways to ask about sexual activity and orientation include:

"Are you currently dating anyone?"
"What is the person like?"
"Have you begun to become physical with that person; I mean kissing or touching in private places?"
"Have you had sex with this person, or with any other person?"
"Are you comfortable with your sexual feelings?"

Use normalizing (legitimizing) statements to follow up on uncertainty:

"What do you mean?"
"Some people feel guilty about thinking about sex and others feel confused about their thoughts, that is pretty normal....” “Do you feel this way?”

**SSHADESS: Safety**

Determine who is likely to be a victim or perpetrator of violence by asking about violence. Interpersonal violence is a primary concern for many youth, and asking about it can save lives. Some believe that a weapon will protect them, despite the evidence that it puts them at greater risk of death. Inquire whether the patient carries a weapon or has access to one. Further, when treating youth for violence-related injuries, explore whether they have plans to “get even”; then look for partner violence by asking about jealousy as well as physical and emotional abuse.

Start with general questions and proceed to more personal ones:

"Are there a lot of fights or weapons at your school or in your neighborhood?"
"Are there weapons at home?"
"Do your friends carry weapons?"

"Do you feel safe at home and at school?"
"Do you get into fights?"
"What makes you mad enough to fight?"
"Have you ever been hurt in a fight?"
"Do you have a weapon?"

"Do you feel safe with your boy/girl-friend?"
"Does s/he get jealous?"
"Has s/he ever hit you or made you feel bad about yourself?"

**STRESSORS, RISK-BEHAVIORS AND SOMATIZATION**

Patients’ responses to SSHADESS inquiry aids understanding of the stressors that drive teens’ engagement in risk-behaviors. In some cases, teens’ adaptation to stress manifests itself as distressing and disruptive somatic / physical symptoms, referred to as “somatization.”

Adolescence is a time of life change in all domains: physical, emotional, vocational, psychological and social. The SSHADESS screen's key goal is to gain a deeper understanding of stressors that patients face. The ups and downs of developmental tasks like socialization, differentiation and autonomy produce stress for all teens and additional stressors such as family disruption, violence, substance abuse, etc., further amplify the stresses of life change. Every teen adopts behavioral strategies that serve to lessen stressful feelings- some “positive” and others “negative.”(Figure 2) Note that the “positive / negative” label reflects culturally determined value systems - not a strategy’s effectiveness at reducing stress. In most cultures, behaviors with negative health
consequences carry the “negative” label; however, some “negative” strategies are quite effective and highly reinforcing in the short term. When adolescents adapt and cope by regularly engaging in a specific risk-behavior, they experience the short term effectiveness in the context of their life. But every clinician has seen tragic consequences, including death, when risk behaviors become ingrained coping mechanisms.

Stress can become the central driver of somatization. While we often consider “stress” an emotion, it is very much a biologic and physical phenomenon. When we experience “stress” we are feeling the effects of adrenaline, cortisol, other hormones, and neurological responses. Our hearts beat faster and stronger; we flush and become overheated. Our gut may experience crampy discomfort as blood is shunted to more critical organs and we begin to breathe faster, often leading to light-headedness. Most teens are unaware that these scary symptoms are simply their bodies’ natural response to stress. Some teens unconsciously relieve emotional stress through generating a somatic symptom for which they seek medical assistance, an effective but ultimately dysfunctional coping strategy. Like most people with “medically unexplained symptoms” (DocCom Module 31), adolescents seldom make the connection between life stresses and body symptoms. Many teens present with somatic complaints such as headache or belly pain for which careful evaluation reveals no specific medical problem. Helping them requires that clinicians adopt counseling strategies and avoid exacerbating patient and family distress (and expense) with additional testing and specialty consultations.

---

**Transition to counseling**

Be explicit with patients about the transition from “examinations” to sharing information and patient education. Begin with respectful feedback, acknowledge risk behavior in life context and seek permission to continue.

After gathering data using the **SSHADESS** mnemonic and completing a physical examination, transition to counseling. The following is a step-wise transition technique that begins with feedback that appreciates strengths and capabilities, then recognizes risk behaviors in the larger context of patients’ lives, and finally, underscores respect for patients’ autonomy by asking for permission to continue risk behavior discussion.

**Appreciate capabilities.**

"Julie, I have really enjoyed talking with you. I have learned a lot about you and I appreciate how honest you have been in talking with me."

**Recognize risk behavior - in context.**

"I admire how much you care about going to college and playing basketball, ... (pause). Also, I am worried that you are not regularly using condoms when you have sex.

**Ask permission.**

"Would you be willing to talk more about this?"

**Offering choice** shows respect and also empowers patients to choose whether to address the issue. When the answer is “yes,” begin to construct a dialogue that is guiding in nature. Rarely is the answer “no,” but if so, respect this choice, offer to dialogue at any time, ask the patient to ponder the issue and ask for permission to bring it up again at a future visit.

"I hear that you don’t want to talk about this now and I appreciate your honesty. I’m here to help you with this, so please think more about the issue. I’m always here to listen or answer your questions. Is it OK if I check in with you about this the next time I see you?"
STRENGTH BASED COUNSELING

Our goal as patient advocates is to empower and strengthen youth – only they can choose to change a behavior. Clinicians too often hinder their counseling effectiveness because of a tendency to mistrust youth and expect the worst from them.

To change any behavior, a person needs both the conviction that the issue is important and a sense of confidence to make change (Ginsburg, 2002c). If the goal for clinicians who advocate for youth is to empower and strengthen them, then doctors must learn about teens’ strengths and capabilities, rather than focus on negative behaviors. Clinicians who listen to youth with their hearts as well as minds inevitably discover traits or actions to respect and admire, and this is true even when unhealthful or very dangerous behaviors are evident. Emphasizing competence by helping youth discover and acknowledge their strengths is not only the first step to mediating positive change, it is also one of the most inspiring moments in interactions with patients.

Not enough teens receive unqualified positive feedback from an adult and feel they have someone advocating for their needs. Many have never felt “seen” or “heard” without judgment or reprimand. When teens are guided to acknowledge their strengths, they tend to be more receptive to learning how to use these capabilities to initiate change of worrisome behaviors.

Bring your own subconscious expectations and biases into awareness and consciously put them aside in order to avoid hampering your effectiveness in essential counseling activities. Most adults do not look past the risk-behaviors and try to understand why the teen is engaging in dangerous coping strategies. Medical professionals see the consequences risky behaviors such as pregnancy, violence and addiction, every single day. As clinicians, we must ask ourselves, “Do I define success for youth in terms of behaviors they avoid rather than who they are?” Carrying low expectations of patients undermines interventions, just as low confidence on patients’ part hampers progress. Do not engage in “blaming the victims” whose strengths are incessantly undermined by detrimental forces in their environment. If we exclusively target risk and limit our focus to drugs, violence and pregnancy-prevention programs, we convey low expectations and send adolescents the implicit message that we expect them to engage in these behaviors.

Counseling: Connect Stress and Risk

Adolescents face stress, derived both from inner anxiety and from difficult interactions with friends or parents. Everyone adopts behaviors that help cope with stress, and teens experiment with many strategies, some healthy, others risky. Many dangerous behaviors are effective stress reducers but have long-term deleterious consequences. (Note: a separate section on counseling about somatic symptoms follows below)
Help adolescents to connect the dots between stressors and harmful behaviors. Helping teen patients view harmful behaviors as typical and normal attempts to deal with stress always requires multiple conversations. Make use of the previously mentioned communication tools with the goal of exploring motivation and readiness to change. Time is required to cement gains in understanding, to discover motivation for changing behavior(s) and to learn from attempts to change. As patients partner with you in this process, encourage them to assent to your request that multidisciplinary partners such as counselors, social workers and psychiatrists join your partnership and lend aid to the process.

Approach these conversations in a stepwise fashion, and consider using the following structure: (1) elicit the main stressors; (2) ask the teen to explore how the behavior relieves stress; (3) lessen shame by reframing the behavior in a positive light; (4) explore negative consequences; (5) brainstorm alternative strategies.

1. **Uncover stressors.** Listen for hints about current or past sources of stress such as bullying, abuse, family violence or drug use, and for clues about behaviors the teen uses to adapt to stress. Gently ask about stressors or adaptations. "What are some things that stress you out? What is the main thing going on in your life that is causing you to want to escape?"

   Young people tend to be aware of the stressors they experience, and can name them if asked to do so in a safe environment: "I get into fights because..." or "I smoke marijuana because ..." or "When I am stressed out, I..." This affords a more comprehensive picture and additional clues for guiding the conversation toward constructive paths.

2. **Explore whether and how the risk-behavior relieves stress.** Some presenting complaints (such as somatization) and most risk-behaviors are stress-driven. Explore contextual details of medically unexplained somatic symptoms, and discover as many connections between behaviors and stressors as possible, as these findings will be
useful when brainstorming alternative methods for stress reduction. "Can we look a little more at where and when the headaches come on?" "What is it about (behavior) that helps you deal with stress? How does it relieve stress?"

3. **Lessen the shame - reframe: the teen has found a way to cope.** Present the hypothesis that the behavior enables the teen to handle some of life’s stresses, so that you legitimize the adaptation. This empathic reframing not only lessens the shame associated with disclosure and exploration of a risk-behavior but also empowers patients by demonstrating that they are actively making decisions and coping with life. "Everyone has to explore ways to cope with stress- it seems like this (behavior) is working for you, at least at present…. What I am hearing you say is that you have found a way to deal with the stress in your life…. Many people, adults even, don’t ever find ways to deal with stress. They just allow the stress to become overwhelming…. Did you realize that you have found at least one way to cope?… What do you think?"

4. **Explore both whether the risk-activity works, and whether there is a negative side.** Elicit information about how effectively the current behavior serves to relieve stress, and also ask about actual and potential negative consequences and drawbacks. Give positive feedback and reflect what the teen has disclosed. Assess whether such an exploration helps the patient to gain insight. "I’d like to help you assess how well (behavior) works to reduce your stress? …How long does the relief last? …How do you feel afterward; does it ever make your stress worse? …Are there other things you don’t like about (behavior)? …I admire that you’ve thought about all these things. …It seems that you have found a way to relieve a little stress in your life, but from what you are telling me, (behavior) makes you more stressed sometimes. …What do you think?"

5. **Ask permission to brainstorm alternate suggestions for stress reduction** (See “Stress Reduction Ideas,” below). State your own AND the teen’s concerns, and ask for feedback. Then, guide patients to develop alternate healthy coping strategies that they might use as lifelong stress reduction techniques. "I’m concerned too about how some of your coping is starting to work against you. …I worry about the not-so-good effects, both today and in the future. …If you could find other ways to help you deal with stress, maybe you wouldn’t feel so bad? …What do you think? …Can we try to come up with some other strategies together?"

---

**Connecting the Dots**

In this section, we explore a structure that helps you assist adolescents in the process of connecting the dots between their own personal stressors and their adoptions of dangerous / risky behaviors.

**Uncover stressors.** Listen for hints about current or past sources of stress such as bullying, abuse, family violence or drug use, and for clues about behaviors the teen uses to adapt to stress. Gently ask about stressors or adaptations.

"What are some things that stress you out? What is the main thing going on in your life that is causing you to want to escape?"

Young people tend to be aware of the stressors they experience, and can name them if asked to do so in a safe environment: *I get into fights because…* or "I smoke marijuana because …" or "When I am stressed out, I…" This affords a more comprehensive picture and additional clues for guiding the conversation toward constructive paths.

**Explore whether and how the risk-behavior relieves stress.** Some presenting complaints (such as somatization) and most risk-behaviors are stress-driven. Explore contextual details of
medically unexplained somatic symptoms, and discover as many connections between behaviors and stressors as possible, as these findings will be useful when brainstorming alternative methods for stress reduction.

"Can we look a little more at where and when the headaches come on?" "What is it about (behavior) that helps you deal with stress? How does it relieve stress?

Lessen the shame - reframe: the teen has found a way to cope. Present the hypothesis that the behavior enables the teen to handle some of life’s stresses, so that you legitimize the adaptation. This empathic reframing not only lessens the shame associated with disclosure and exploration of a risk-behavior but also empowers patients by demonstrating that they are actively making decisions and coping with life.

“Everyone has to explore ways to cope with stress- it seems like this (behavior) is working for you, at least at present.... What I am hearing you say is that you have found a way to deal with the stress in your life.... Many people, adults even, don’t ever find ways to deal with stress. They just allow the stress to become overwhelming.... Did you realize that you have found at least one way to cope?... What do you think?”

Explore both whether the risk-activity works, and whether there is a negative side. Elicit information about how effectively the current behavior serves to relieve stress, and also ask about actual and potential negative consequences and drawbacks. Give positive feedback and reflect what the teen has disclosed. Assess whether such an exploration helps the patient to gain insight. "I'd like to help you assess how well (behavior) works to reduce your stress? ...How long does the relief last? ...How do you feel afterward; does it ever make your stress worse? ....Are there other things you don’t like about (behavior)? ....I admire that you’ve thought about all these things. ...It seems that you have found a way to relieve a little stress in your life, but from what you are telling me, (behavior) makes you more stressed sometimes. ...What do you think?”

Ask permission to brainstorm alternate suggestions for stress reduction. State your own AND the teen’s concerns, and ask for feedback. Then, guide patients to develop alternate healthy coping strategies that they might use as lifelong stress reduction techniques. (See “Stress Reduction Ideas,” below)

“I’m concerned too about how some of your coping is starting to work against you. ...I worry about the not-so-good effects, both today and in the future. ....If you could find other ways to help you deal with stress, maybe you wouldn’t feel so bad? ...What do you think? ...Can we try to come up with some other strategies together?”

Counseling: Advise

Facilitate a discussion that avoids lecturing, and help break down large abstract concepts into a series of small concrete steps. Use communication techniques such as the choreographed conversation, role-playing, and the decision tree to involve the teen in brainstorming different approaches to stressors.

Adolescents are concrete thinkers whose brains have not matured sufficiently to routinely consider the consequences of their actions. Research using functional MRI has shown that neuronal connections between the regulatory center of the brain in the prefrontal cortex and the hormonally sensitive, reward-and impulse-driven area in the limbic system does not fully mature until the mid-20’s (Steinberg, 2007). This means that young persons seldom consider consequences when making in-the-moment decisions; in effect, they are at the mercy of hormonal drives.

Your role in addressing risk-behavior is to help teens to examine future consequences of their current actions, to identify their positive capabilities and help them acknowledge their strengths, and then to mobilize these strengths to examine worrisome behaviors and plan for changing them.

When patients assent to discussion, the fundamental goal is to assist these concrete thinkers in an
examination of their actions. In general, advice provided in a format that might—even remotely—be perceived as a lecture, is guaranteed to shut down youths' receptivity to taking action. In terms of "good" communication strategies, ask guiding questions, give positive feedback, and reflect back the teens' answers. Include an opportunity for teens to examine possible underlying motivations for the behavior—such as stress, a need to "fit in," etc. Even if given in a neutral and non-condescending tone, a bolus of information in which the clinician connects behavior and consequences puts off the patient. Use the complementary strategies described below.

A "choreographed conversation," a "decision tree," or a brief "rehearsal" can channel the counseling to an assessment of both the immediate and longer term consequences of risky behavior. This dialogue breaks down abstract concepts into simple, concrete and understandable steps. Exploring steps in sequence allows patients to discover the key points themselves reach conclusions on their own. The process leads teens to an abstract realization of why the risk behavior is harmful, what we call a "Cognitive Ah-Ha! Moment"(Ginsburg, 2001). See sections below for more detail about implementing these strategies.

The Choreographed Conversation

The choreographed conversation is a planned and loosely formatted dialogue that begins with questions to help teens explore the problem from different angles. The clinician conveys several points to the patient, and helps brainstorm other points by asking guiding questions and by reflecting back the teen’s answers. Include empowering feedback with the reflections to assist patients to discern key concepts and to develop a sense of self-efficacy. The following sample questions could be used to guide a young woman to a conscious connection between using condoms and the STDs she is worried about. A similar set of questions could help her consider the consequences of getting pregnant and how that would affect her dreams of going to college and playing basketball.

Some sample “choreographed” questions / reflections, with empowering feedback include:

"Julie, what are condoms for anyway? What do they do?"

"I appreciate your ability to talk about this—it is often a difficult subject. What do you mean infections? Which ones are you worried about?"

"You know a lot about these things. Doctors worry about these infections, too. Tell me more about why YOU worry about infections."

"Yes, Chlamydia and Gonorrhea can hurt a lot, especially if they go up into your fallopian tubes and ovaries. And just like you said, people die from HIV and there still is no cure. There are also some diseases that we don’t have good tests for that a person may not know they have, like herpes."

"And those are all good reasons to use condoms."

"So how come you are not using condoms every time you have sex?"

The Decision Tree
Another technique is the decision tree, essentially a choreographed conversation written out on paper. Ask guiding questions to discover alternate, often unintended outcomes and use a writing surface to illustrate the process and help adolescents to visualize these potential outcomes. The product is a diagram that represents a series of choices leading to the outcomes. An additional bonus of the decision tree is that patients can take home the diagram to contemplate further.

This decision tree (Figure) was used with a 14-year-old girl, who presented with a scleral hemorrhage in a school-based clinic. She became mad enough to fight when a girl insulted her mother. When asked what was going to happen next, she responded “I'm going to kill her, that's why I brought this knife (which she had in her pocket) to school.” When asked how that would make her feel, she responded, "Good!" When asked how long she would feel good she responded "All day!"

She needed a tool that would help her contemplate an important future consequence, namely, how her actions would affect her mother, since she fought to protect her mother's honor. Her clinician asked questions that helped her brainstorm different scenarios and outcomes, examine and weigh the consequences and develop the decision tree shown in the figure.

![Decision Tree Diagram](image)

---

**REHEARSAL**

Another counseling technique is rehearsal (DocCom Module 10). Most people need to practice verbalizing realizations gained during a conversation or brainstorming session. To introduce this technique, use terms like “practice” or “rehearse” instead of “role play,” a concept that would generally bring to mind “on stage” or “performing” and potentially make teens feel uncomfortable.
However, remain in professional role, do not use teen language (current or past slang) and describe concepts in a simple, concrete fashion. Provide positive feedback for the answers she gives, and add information and phrasing that may be helpful to integrate into her mock dialogue.

Some ways to speak about rehearsal might include:

"You’ve shown me that you can think pretty clearly about this. Let’s practice what you will say to your boyfriend if he does not want to use condoms......"  "The way you said that seems convincing to me. What if he then says, ‘Why do you want to use condoms, don’t you trust me?’

*Can we rehearse together what you might say?*

"That’s great, and I know you have coped well with some other complex situations before this. Now, what if he says, ‘I’ve been checked for every disease; I don’t have anything.’

*What would you say?*

---

**CONNECT STRESS AND SOMATIC SYMPTOMS**

The stress reaction alerts people to presence of danger. This adaptive biologic reaction can and does produce physical symptoms that sometimes reach the level of somatization – the teen is disabled by somatic symptoms. Facilitate healing both by attentive listening to symptoms and perspectives and by describing links between stress and physical symptoms. Build trusting relationships over time by repeated listening and examining, while minimizing testing.

For patients who are experiencing somatization, that is, disabling somatic symptoms, your goal is to facilitate healing by helping them understand that body and mind are integrated.

The following discrete steps all contribute expanding patients' understanding:

1. obtain a thorough and comprehensive history;
2. elicit the patient's illness perspective;
3. perform a thorough physical exam;
4. be transparent in your findings and assessment;
5. discuss your differential diagnosis, and include the possibility that the symptom is stress related;
6. clarify the mechanisms that translate psychic and environmental stresses into somatic symptoms;
7. reduce shame associated with somatization by validating and normalizing symptoms;
8. make a diagnostic and treatment plan and ask the patient for buy-in.

---

**Somatization: Exploration**

Engage the patient by eliciting all aspects of the symptoms, eliciting their perspectives, and being transparent about the exam and findings.

1. **Obtain a thorough and comprehensive medical history.** Utilize active listening skills to demonstrate engagement with the patient’s story and suffering. When patients suffering from somatic complaints feel engagement and accurate reflections of their distress, they become less anxious and mistrusting. Listen to the whole story as long as it takes, until the patient is done. Ask questions about associated symptoms and timing of the presenting complaint. Elicit the SHADDESS screen, and past and present stresses. Retell the story
including the new information, and elicit feedback from the patient about your understanding.

2. **Elicit the patient’s illness perspective.** Ask the teen and parent to provide their perspective on the symptom. A helpful patient-centered technique that elicits the patient’s illness perspective is called FIFE (Rosenberg, 1997). FIFE is a mnemonic that stands for **Feelings/Fears** (What are you most afraid is going on?), **Ideas/Instincts** (What do you think is going on? What is your instinct about what is going on?), **Function** (How has this affected what you can do and want to do?) and **Expectations** (What are your expectations from today’s visit and what can I help you with most right now?).

3. **Perform a thorough physical exam.** As the exam is done, address specifically and with transparency the patients’ central fears and instincts. Link this strategy with the FIFE technique because it provides an opportunity to reassure patients that is pertinent to their central concern, such as headaches, dizziness or belly pain.

4. **Be transparent about findings.** As the exam is done, give voice to your thinking, as this level of transparency reassures patients not only about your concern for their suffering, but also about your thoroughness and the lack of suspicious findings.

---

**Somatization: Initial Management**

Somatization is mysterious and embarrassing. Management of the adolescent with disabling somatic symptoms begins with introducing the possibility of a stress-related condition, discussing how stress might produce the disorder, normalizing the stress response and finding common ground about a treatment plan.

1. **Discuss the assessment and differential diagnosis, and include the possibility of a stress-related diagnosis.** Of course, keep an open mind about symptoms so that diseases other than somatization are not ignored or missed. In discussion, state the possibility that the symptom(s) could be stress related and that this is a common adaptation to stress. Negative test results will then confirm this possibility at a subsequent visit. Waiting until another visit to even mention possible stress adaptation often leads patients to think doctors are defaulting to “it’s all in your head” because they did not order the right test to find the “right” diagnosis.

2. **Discuss the mechanism.** Take time to explain the biology. Guide patients past their natural and expected skepticism by saying that stress – from emotions or other sources – produces hormones like adrenaline and cortisol and leads to intense, diverse and sometimes devastating effects over time.

   First ask, "How old are you?"

   "Most people your age are not able to answer this question yet. It is something most people don’t figure out until they are much older."

   "But, have you noticed that you are more likely to have (symptom) if you are having a strong emotion, like being stressed, angry, or sad?"

   "Before you answer, let me tell you what I am asking. I absolutely know you are having (symptom); I am not asking if you are faking or crazy. You see the mind and the body are connected in ways we barely understand. And, everyone is a little different."
3. **Reduce shame.** Recognize the inherent shame people carry about somatization. Minimize shame by repeating that the symptom is a common, normal and predictable (but dysfunctional) result of the body’s response to stress. If parents are present, ask them what happens in their bodies when they are stressed. Clinicians might even discuss their own body’s stress reaction, and underscore body complexity that makes people experience stress differently one from another. When patients continue to reject the explanation, assuming clinicians believe that they are “faking” or “crazy,” explicitly deny this notion. Provide anecdotes about successful symptom remission in prior patients.

"For me, I get nausea with immediate stress, headaches with a couple of hours of stress, and I can't sleep if stress lasts for more than a day."

Turning to parent, "What does your body do when you are stressed?"

Demonstrating a caring attitude towards the parent allows the teen to witness a therapeutic interaction about stress-related symptoms.

4. **Make a plan and ask for buy in.** If testing is warranted, tell the patient what tests you are planning on ordering. If you know that the patient/parent expects a certain test ordered (from the FIFE technique), address this now, supporting whether tests are warranted by physical exam and overall assessment. Minimize testing, but state that certainty is elusive in medical practice, so careful follow up is essential and routine. Declare openness to future testing as indicated by developments. Discuss test risks, such as those from radiation with XRAYS and CT scans to help patients and parents realize that there are inherent drawbacks to testing, and that delaying certain tests is a wise strategy.

"Have you noticed the body-mind connection in you yet?"

**If YES:**** Great, that’s very helpful. But it’s my job to worry and to make sure I don’t miss the big things. So I am going to do a thorough exam and might even do some tests. Will you agree that if I decide that this may be stress related, we can come up with a plan to deal with that?"

**If NO:**** Ok, either way, I am going to do a thorough exam and may even do some tests. Then, if I don’t have an answer yet, I am going to send you home with a diary. Every time that you have a ---, I want you to answer all of those questions I asked today, about food, location etc, including its timing compared to stress. Ok? Will you agree that if I decide this may be stress related, we can work together to come up with a plan to deal with that?”

**Check out the video example** of beginning to counsel a patient who is suffering severe somatic symptoms.

---

**Somatization: Continuing Management**

Minor somatic complaints often resolve after a thorough history and careful exam that includes
trust building empathic statements and some exploration of belief systems. Adding an exploration of alternative coping strategies provides additional help when working with major disabling symptoms.

At later visits, as patients begin to accept that physical symptoms are stress-related, explore alternate coping strategies that include physical, spiritual, and creative outlets that can expand patients’ repertoire for handling stress. Use the Stress Reduction plan outlined in the next section, and reassure the family that you will continue to address their concerns. Remain alert to the possibility of other underlying causes, continue to review the history and physical, and proceed cautiously with procedures that have their own risks and tend to divert attention from the primary mind-body issues.

The steps outlined for somatization management are specifically tailored for disabling unexplained symptoms. However, experienced practitioners confronting any new symptom elicit patients’ concerns and beliefs up front, and many integrate the FIFE inquiries into such encounters. Using the tools discussed, they expand the conversation and build trust. Furthermore, every symptom has some emotional component, whose size and impact remain hidden until explored in conversation. This exploration provides information about patients’ beliefs, and is simultaneously also therapeutic (DocCom Module 3.)

**IDEAS FOR STRESS REDUCTION**

These are suggestions for teens on dealing with stress. You should review the topics with the teen during the visit, but can also give the teen a handout to take home.

1. **Exercise**
   - Listen to your body: when you are stressed, your body is saying RUN and you need to get rid of the stress hormones!!!!
   - When you use up those hormones, you will concentrate/think better.
   - Exercise every day to control stress and to build a strong, healthy body.

2. **Fool your body into thinking that you are relaxed**
   - Breathe deeply and slowly.
   - Put your body in a relaxed position- tell your body there is no emergency!
   - Visualize yourself in a calm, beautiful place. Close your eyes and go there for 1 minute. Recline and take deep breaths while you are there.

3. **Let it out!! Deal with the Emotions: Don’t hold all of your feelings inside.**
   - Find someone (who deserves your trust) to share your feelings with and get advice from them. Many teenagers benefit from an extra adult relationship with a teacher, counselor, or medical provider.
   - Be creative!! Things like music, poetry, writing, singing, dance, or rapping are ALL powerful ways to let your feelings out.
   - Deal with only one problem at a time.
     1. Sometimes feelings become so overwhelming that we put them away in a box, thinking we will deal with them later.
     2. Once there is too much in the box it becomes terrifying to open – and we don’t deal with anything.
     3. The box can overflow, especially when we are angry or frustrated
     4. Pick just one problem to deal with and forget all the rest.
     5. Find a calm, quiet place, breathe deeply, and think, talk, or write about only one problem at a time.

4. **Take time for yourself**
   - Everyone deserves some private time, something special every day.
   - Time to think, to relax, and to do something that makes you happy: meditate, pray,
take a bath, take a walk, and be creative!

5. **Get it done...then play!**
   - Putting things off creates more stress because you are worrying about the work you still have to do.
   - Make a plan: Have fun exercising and burn off those stress hormones; then get your work done; then enjoy the rest of the night without worry!

6. **Lastly: Sleep 8 hours regularly, eat healthfully, and brainstorm your own ideas for stress reduction!!!!**

---

**CONCLUSION**

Helping youth discern what stress-relieving strategies work best for them is seldom achieved in one visit; neither is guiding teens completely away from risk-behavior.

While we rarely witness an overnight transformation, we can help adolescents recognize and build on their existing competencies. We can help them not only to link risk-behavior with stress but also to learn the skills to initiate alternate strategies so as to lessen their reliance on unhealthy and dangerous solutions. Join with adolescent patients and their parents to develop trusting and non-judgmental relationships.

Express your appreciation of their dilemmas and your respect for their successes, and use a strength-based approach to addressing risk-behaviors.

Learn effective skills for exploring linkages between stress, behavior and symptoms, and for brainstorming new options and making new choices that build upon patients’ existing strengths and facilitate additional successes in their lives.

---

**RELEVANT BEHAVIORS**

1. Consistently project an open, non-judgmental attitude and demeanor throughout the entire encounter.

2. “Set the stage” with each new patient and briefly with returning patients. This includes explaining why private information (medical and personal) will be asked of the teen and what will be done with the information (i.e. confidentiality).

3. Discuss confidentiality with each adolescent patient using concrete words that the teen will understand.

4. Involve parents as much as possible, but always focus primarily on the teen as the center of the interview. The provider should plan to spend time alone with each adolescent patient.

5. Attempt to elicit the SSHADESS screen in a free-flowing dialogue that is focused on eliciting the teen’s strengths as well as risk behaviors. **SSHADESS**: Strengths, School, Home, Activities, Drugs, Emotions (depression/suicidality), Sexuality and Safety

6. Maximize safe and honest communication with the teen by eliciting the entire SSHADESS screen first before addressing any risk behavior. This approach projects the attitude that the provider is interesting in learning about the entire life and situation of the teen, not just about what the teen is “doing wrong.”
7. Try to be aware of personal reactions, biases, and expectations. This will help the provider remain non-judgmental as s/he listens to the teen.

8. Approach behavioral change with patients using a strength-based tactic. This means focusing first on what teens are “doing right”, then helping them find solutions to their current problems.

9. Avoid lecturing. Instead, when addressing risk-behavior, the provider should get teens involved in brainstorming their own solutions by using techniques such as the choreographed conversation, role-playing, and the decision-tree.

10. Ask every teen about their current stressors at each encounter. This approach will help minimize the stigma of stress and will also help the provider with current or future interventions that may involve somatization or stress-reduction.

---

**LITERATURE REFERENCES**


loading..
Welcome to DocCom Module 23: "Communicating with Geriatric Patients"

by Brent C. Williams, MD, MPH and James T. Pacala, MD, MS

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Brent C. Williams, M.D., M.P.H. and James T. Pacala, M.D., M.S.

Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.

DocCom implementation: Christof Daetwyler M.D.

Casting of the Standardized Patients: Benita Brown

Standardized Patients: Felecia Myers, Blanche Watts

"Actors" and Panel Participants: Lauren J. Van Scoy M.D., Chileshe Nkonde M.D., Mary Coté M.D., Walter Cohen D.M.D.

Clinician on camera: Brent C. Williams, M.D., M.P.H.

Video Director and Producer: Christof Daetwyler M.D.

Video Camera, Light and Sound: George Zeiset B.A.

Video Assoc. Director: Dennis Novack M.D.

Version History: 3.0 - 10/14/2011 - HTML5 version implemented - iPod fully supported
2.1 - 12/01/2010 Revision by authors
2.0 - 7/16/2009 - Upgrade to version 4.0 of DocCom
1.1 - 7/15/2009 - Revision by the editors
1.0 - 11/26/2008
Rationale
by Brent C. Williams, MD, MPH

The Patient's View

The Doctor's View

Questions for Reflection:

- What do you fear most about your own aging?
- In what ways do you care for older patients differently than younger patients with similar conditions and life expectancy?
- How do you feel when you are about to see a frail older patient who is medically complex and functionally impaired?
- Perhaps: Overwhelmed? Worried about your ability to assess and manage the patient? Anxious about keeping on schedule?
- When you discuss death and dying, do you fear your patients lose faith in you as a doctor?
- What are your feelings when you consider discussing complex decisions with patients (such as the decision not to pursue diagnosis or treatment; decisions about advance directives?)

Key Concepts:

1. Overcoming communication barriers such as sensory and cognitive impairments, the presence of multiple illnesses, and vague or downplayed symptoms improves care.

2. Addressing patients before caregivers, even if patients are cognitively impaired or debilitated, and establishing their preferences about decision-making enhances trust.

3. Asking patients directly about sensitive topics, such as end-of-life values, suicidality, driving impairment and abuse and neglect improves assessment.

4. Even with cognitively impaired patients, encouraging a culture of open decision-making that involves caregivers (with permission) facilitates adherence.

5. Assessing stress levels in caregivers and supporting them enhances care.
Learning goals:

At the conclusion of this module, you will be able to:

- Overcome communication barriers such as sensory and cognitive impairments and pursue vague or downplayed symptoms.
- Even if patients are cognitively impaired or debilitated, address patients and establish their preferences about decision-making, before addressing caregivers.
- Ask patients directly about sensitive topics, such as end-of-life values, suicidality, abuse and neglect and driving impairment.
- Even with cognitively impaired patients, encourage a culture of open decision-making that involves caregivers (with permission).
- Assess stress levels in caregivers and help them reduce caregiver burden.
- Welcome and value collaboration, and process conflicts with other health professionals when providing care to older patients.

INTRODUCTION

Older patients are a large and growing portion of the practice of every clinician who cares for adults. Communicating with older patients, many of whom have multiple complex, interacting problems can be daunting, especially when time is limited.

In this module, we review techniques for communicating effectively with older patients, especially those with sensory, cognitive, and functional impairments, and for interacting with their caregivers. These skills and strategies assist clinicians in making more comprehensive diagnoses as well as effective and informed joint decisions with patients and their caregivers during relatively brief encounters.

We also provide an opportunity for learners to examine their own assumptions, values, and beliefs related to aging that may influence medical decision-making. We show how ageism, comprised of negative attitudes about the elderly, can influence care.

Ageism in Health Care

Learners’ exposure to frail older adults who communicate poorly can result in negative stereotyping; this is ageism. When ageism is unexamined, it impairs trust and communication with both patients and colleagues, and diminishes the quality of care provided to elderly patients.

Medical training exposes students and residents to a disproportionately ill population of older adults. Learners in the health professions interact less frequently with healthy older adults, who far outnumber those who are chronically ill or frail. Hospitals and chronic care facilities are filled with
elderly persons who have complex problems that are difficult to diagnose and treat, and who frequently communicate slowly or poorly. Extensive and repetitive exposure to the sickest of older adults often results in negative stereotyping of the entire geriatric population by medical learners (1). Learning to provide high quality care to this population requires that students recognize and reflect on this bias, as everyone must do with other important stereotypes to which everyone is subject, such as racism or sexism.

Ageism, like other biases, frequently operates at a subconscious level but nevertheless can strongly influence the way we view older patients, provoking negative attitudes toward caring for them, inaccurate assumptions regarding their functionality and preferences for care, and erroneously poor estimates of their prognoses. This bias can also adversely affect interactions with patients, impairing communication, trust and other important aspects of the doctor-patient relationship. Awareness of the effects of medical education on promoting negative attitudes, introspection into feelings about older adults, and interaction with healthy elderly can serve to minimize ageism. (2)

Ageism can also insidiously affect how medical colleagues interact with one another. Negative comments regarding both elderly patients and clinicians headed for careers in geriatrics abound in medical education settings, perpetuated by students, residents, and attending clinicians. These attitudes are typically fostered outside of formal educational settings and thus constitute an “informal curriculum” that promotes ageism. Upholding standards of medical professionalism requires that you do your part in creating a work environment that is respectful of patients and coworkers, through actions such as using respectful language when speaking of older adult patients, initiating conversation with a colleague who behaves or speaks inappropriately, and raising awareness of professionalism in the work place.

Later in this module, several videos illustrate how attitudes can affect care of the elderly.

**Give Yourself the Time Needed for Elderly Patients**

Develop and use strategies that will prevent frustrations about time and the resulting impairment of trust.

You will be frustrated if you enter a geriatric interview with the same temporal expectations you would have for interviewing a younger patient, and your frustration will likely result in behaviors that impair establishment of trust. It takes more time to interview older patients. Simply from having lived longer, they have more history to report, and their medical problems are often more numerous. Typical conditions of older adults, such as Parkinson’s disease, strokes, or dementia, retard response times to your queries. Time constraints can be mitigated by:

- altering your schedule to allot more time with older patients
- asking your patient or caregiver to fill out a questionnaire before the visit. This questionnaire can include H&P questions, as well as questions about concerns, need for medication renewals, etc.
- setting an agenda and prioritizing topics at the outset of the interview, perhaps saying, “What are the three main problems you would like to address today? (See Modules 5 and 7.)
- dividing the interview into more than one session

**Before starting the Interview**
Review the patient’s record, arrange the environment, check for comfort, vision and hearing, and decide whether to include a partner or caregiver.

Prior to interviewing elderly patients, especially those with complex problems, review the record, even if only to refresh yourself about the patient’s problems and medications. After arranging the physical environment for optimal communication, check the patient’s comfort level and suitability for effective communication.

Finally, before beginning the actual interview, make an explicit decision about whether or not a caregiver or spouse should be present, and make it so. While caregivers can often provide important information, the patient’s wishes regarding their presence and input must be solicited and respected.

Probably the simplest way to establish this is to ask the patient,

- Can you see and hear me OK?
- Are you comfortable?
- Would you prefer that (your caregiver) leave the room, or join us?

Communicate with Caregivers

Caregivers provide essential support for many older patients and are part of the care giving team. Communicate and collaborate with your patients’ caregivers while maintaining patient autonomy and confidentiality.

For older patients who receive ongoing care from paid or unpaid caregivers, the therapeutic relationship is no longer a dyad, but a triad. Caregivers are usually a family member, often a daughter or daughter-in-law, who accompanies the patient to visits and communicates with the clinician or other clinical staff between visits. Remain patient-centered, negotiate confidentiality issues and be alert to patient-caregiver relationship problems.

Begin with the Patient

In private, elicit patients’ preferences about your communications with caregivers, seek permission to share information with caregivers, and ask about sensitive topics such as relationship with the caregiver and sexual activity.

Spend time alone with the patient, at the beginning of your relationship and periodically thereafter. This usually means asking the caregiver to leave the room for a portion of the visit. Use simple, direct language.

- "It’s important that I spend time alone with each of my patients. Would you mind stepping out for just a few minutes? Just wait in the (hallway, lobby)-- I’ll come get you."

If caregivers raise concerns about leaving the room, these expressions are usually important “openers” to learn more about unspoken concerns, anxieties, stress, or tension between the patient and caregiver.

Check with the patient about how they want you to communicate with caregiver(s) about their health, and specifically ask their permission to share information with caregivers. Establish confidentiality rules, even with patients with mild-to-moderate dementia. Emphasize that you can
During your time alone with patients:

- ASK, “Is there something you would like to discuss while we have this privacy?”
- COMPARE patients’ presence with and without the caregiver.
  - Does the patient’s affect or nonverbal behavior change?
  - Does the patient appear more or less agitated or anxious without the caregiver present?

Observed differences may be clues to the relationship between patient and caregiver. Be alert to the possibility that they amount to warnings of abuse or neglect.

- ASK about sensitive areas, especially the caregiver and sexual concerns.
  - About relationship with the caregiver, you might ask:
    - "What do you and (the caregiver) disagree most about?" or
    - "Do you feel nervous or afraid with (the caregiver)?"
  - About sexual concerns, you might ask:
    - "Do you have any concerns or questions about sex or sexual activity?"

---

**Keep Patient at the Center**

Greet the patient first and begin each interview by conversing directly with the patient – even if demented or verbally impaired-- so that you can better assess the patient and also model effective communication strategies for the caregiver.

For patients with impaired communication, you might explain your wish to begin with the patient by saying,

- "I’d like to assure you that the accuracy of the patient’s report is not as important as my having this direct communication," and
- "I’ll surely give you a chance to fill in the story from your caregiver’s perspective."

As with any important conversation where time is an issue, you and the caregiver will likely need to negotiate and reach agreement on who talks when. An open, direct, warm approach in asking the caregiver to hold their comments is nearly always effective in achieving a therapeutic alliance with the caregiver. Information from this negotiation process may help guide your patient interview as well as shed light on positive and negative aspects of the patient-caregiver relationship.

---

**Include the Caregiver as a Member of the Healthcare Team**

After patients give permission to share information with the caregiver, use the three-way conversation to assess the caregiver, coach the patient and caregiver about day-to-day management issues, and clarify priorities and values most important for the patient.

Assess caregiver stress through direct inquiry, either with the patient present if rapport is strong and the patient and caregiver have demonstrated effective, open communication, or in a private conversation. If separate from the patient, you might briefly explain the purpose of the conversation by saying,

- "I’d like to see how (the caregiver) is doing, in a private conversation."
The stress of caring for an impaired parent or other relative surprisingly often provokes abuse or neglect by people who are otherwise quite competent and stable, particularly if impairment is from dementia. “Prescribe” time away from the patient to alleviate guilt and decrease caregiver stress. Say something like,

“Experience shows that the kind of attention required from you on behalf of the patient is very stressful. I always prescribe “time off” for caregivers. How are you doing?”

Provide caregivers with information and coaching on use of resources such as books (3), support groups, counseling services, and social workers who can advise them on local options for living arrangements and in-home support.

PHYSICAL, SENSORY AND COGNITIVE DEFICITS

With very simple measures, unfortunately often overlooked by busy clinicians, you can overcome communication barriers that derive from patients’ sensory, physical, or cognitive impairments.

Many older adults have chronic conditions causing sensory, physical, and cognitive deficits that can impair communication with medical providers.

When interviewing younger patients, we often safely assume that such deficits are not present. To facilitate effective communication with the older adult, however, you must check for such deficits and compensate for any that are present. Before getting started with the interview, you can first optimize the physical environment to facilitate communication via the measures described below.

Sensory Impairments

Patients cannot communicate well unless they can hear you and see you.

Both conductive and sensorineural loss hearing deficits increase exponentially with age. Optimize patients’ hearing with the following measures:

- Clear the ear canal of cerumen.
- Conduct the interview in a quiet room.
- Ensure proper placement and functioning of hearing aids.
- Face the patient and avoiding glare (see above) to aid lip-reading.
- Use proper vocal pacing and pitch.

Click on the picture-button on the left to play a video in which Dr. Williams communicates with a hearing impaired patient.
Visual impairments increase exponentially with age, and stem from three main causes: refractive error, cataracts, and macular degeneration. To ensure optimal visual functioning, take the following actions before commencing with the interview:

- Make sure that patients have their glasses on.
- Minimize glare, which is particularly troublesome for those with cataracts. Avoid back lighting, by not positioning yourself in front of a window or other light source. Ideally, the room should be illuminated with indirect lighting.
- Maximize acuity. For patients with severe visual impairment, sit closer and use nametags printed with a large font.

*Click on the picture-button on the left to play a video in which Dr. Williams communicates with a visually impaired patient.*

---

**Physical Deficits**

Ask about physical comfort and take measures to assure it.

Older adults with conditions impairing posture or mobility pose other obstacles to effective interviewing. To eliminate the potential perception of a power differential between you and your patient and to facilitate communication, position yourself level with the patient’s eyes. This may mean sitting or kneeling next to a patient in a wheelchair, and even sitting on the floor to look directly at a patient with a pronounced thoracic kyphosis.

Older patients may have numerous conditions that render it painful to sit or lie in certain positions. As with all interviews, patient comfort must be maximized, and assuring comfort warrants a simple inquiry into a patient’s comfort before beginning the rest of the interview.

---

**Cognitive Deficits**

Detecting and compensating for cognitive deficits is a complex and nuanced endeavor. In order to discern cognitive dysfunction, you will remain alert for clues that arise during your interview. Confirm deficits with formal mental status testing, and solicit information from caregivers.

Minimizing sensory and physical obstacles to interviewing is relatively straightforward through direct inquiry and manipulation of the physical surroundings. Many cognitively impaired patients lack insight into their deficits, and those aware of impaired cognition may be defensive or embarrassed. You will usually discern impaired functioning by observing clues that surface through the course of the interview, rather than asking patients directly about cognitive status. The clues you may notice include the following signs of cognitive impairment:
• Evasive or defensive responses to innocuous questions ("Oh, I don’t work anymore so I don’t need know what day it is.")
• Lack of specificity regarding recall of recent events
• Excessive use of “pat,” or simplistic responses
• Reliance on a caregiver or spouse to provide answers to queries
• Difficulty with word finding

Keep in mind that social behaviors are retained in early dementia, so you can be easily fooled into thinking that a well-dressed, socially appropriate demented patient is cognitively intact. If you suspect the presence of cognitive impairment, you must confirm it through formal mental status testing during the physical examination portion of the patient visit. Before that, however, you can pose certain other questions during the interview to gather more information, such as the following:

• "How do your days go - what do you do in a typical day, lately?" A lack of specificity in the patient’s description heightens suspicion of a cognitive problem.
• "What have you heard about recent important news, in the world or locally?"
• "Would you fill me in on some recent medical events in your life?"

When you are having difficulty obtaining information from a patient that you suspect has cognitive impairment, soliciting further information from a caregiver or spouse (with the patient’s consent) is often very helpful (see “Communicating with Cognitively Impaired Patients” section in this module).

---

**GATHERING DATA**

In this “Gathering Data” segment, we discuss how older patients’ symptom descriptions differ from typical descriptions, with emphasis on vague and downplayed symptoms. We note that attention to structured routines- for example, about past history and review of systems- is of special importance in establishing diagnosis and making treatment plans with the elderly.

This chapter is divided into two sub-chapters:

• **Symptoms**
  Often, very significant or serious diseases in older patients do not present themselves as well-described symptoms or appear to you as typical syndromes. Explore symptoms carefully, despite their vague character or patients’ downplaying of them.

• **Routines**
  Certain elements of “routine” data gathering tend to have more importance in the management of your elderly patients. Attend to details about patients’ psychosocial context, past history, medications and review of systems.

---

**Gathering Data: Symptoms**

Often, very significant or serious diseases in older patients do not present themselves as well-described symptoms or appear to you as typical syndromes. Explore symptoms carefully, despite their vague character or patients’ downplaying of them.

• *Downplaying meaning of symptoms.* Research shows that older adults tend to downplay or underreport symptoms. (4,5) Be aware that comments downplayed symptoms are cues to
pursue the complaint further, because patients often ascribe abnormal symptoms to a normal aging process. Typical comments sound like:
- "It’s nothing really” or
- "It’s just age, I guess”

- Vague complaints. The sensitivity and specificity of symptoms for predicting specific conditions decrease with age. “Classic” presentations are less common and atypical presentations more frequent. A complaint of “a little indigestion” could simply indicate dyspepsia – but it frequently indicates angina or intestinal ischemia. Carefully and methodically exploring vague complaints and discovering their cause is a challenge.

- Geriatric syndromes. Frail older adults with many illnesses often experience “geriatric syndromes.” This term refers to the common symptomatic endpoints of the interplay of multiple medical conditions and psychosocial stressors. Common syndromes include confusion, incontinence, frequent falls, immobility, nonspecific functional decline, and weight loss. These syndromes seldom arise from a single cause when they appear in frail elderly patients. Employ an interdisciplinary, team approach to establish the proper diagnosis and management plans (see next section).

### Gathering Data: Routines

Certain elements of “routine” data gathering tend to have more importance in the management of your elderly patients.(6) Attend to details about patients’ psychosocial context, past history, medications and review of systems.

- Past history. When assuming the care of older patients, conduct a comprehensive review of their past history. Reviews are often tedious and time-consuming, but essential for gaining a sense of the medical trajectory of the patient’s life. Careful reviews also minimize duplication of testing and of expensive consultations that may be enervating for patients.

- Medication review. About one-quarter of older adults take 5 or more prescription drugs. Adverse drug reactions are a common cause of symptoms and severe illness in the elderly. Few people who require multiple medications can recite the details succinctly, particularly when time is short, and we suggest using the “brown bag” method for medication review. Instruct the patient or caregiver to put all medicines and supplements into a bag and bring them to the visit. A trained medical assistant or nurse can then review the medications, compare them to the medication record, and report the results to you.

- Psychosocial context. A patient’s living situation, family (and other) conflicts and supports, availability of caregivers, and ability to perform activities of daily living and instrumental activities such as driving or shopping shape all medical diagnostic and management decisions. Establish the patient’s functional status with a thorough exploration of psychosocial factors. Ask about sensitive topics such as sexual activity and about relationships with caregivers. Screen for abuse or neglect.

- Family history. When pressed for time, the family history is one area of the geriatric interview that can be abbreviated. You take a family history to discern familial patterns of premature disease in order to screen or monitor such conditions. By definition, however, the elderly do not have premature disease.

- Review of systems. As a group, older adults usually have more medical conditions and more positives in the review of systems than younger patients. Minimize the problems that result from underreporting of symptoms by performing a diligent review of systems and working through any positives.
Understanding Patients' Functional Status and Preferences for Care

Decision-making with older patients is complex and nuanced, and frequently requires that you balance complicated medical conditions, patient values, and prognostic considerations.

Establishing trust is an important goal of any patient interview, and holds true with older patients. General methods for fostering trust are considered in detail in Modules 5 and 6. Attend particularly to using open-ended questions at the beginning and to responding to both verbally and non-verbally expressed.

Geriatrics is a functionally-based discipline, and warrants respectful inquiry about a patient’s living situation, functional status, outlook on life, and preferences for care. Some open ended questions that help to establish this information might include:

- **Living situation:**
  "Tell me about where you are living."
  "Who else is at home?"

- **Functional status:**
  "How are you able to get along through the course of a typical day?"
  "Could you describe a day for me?"

- **Outlook on life:**
  "What is the best thing about your life right now? - "What is the worst thing?"
  "On a scale from 0 to 100, where 100 is the best life you can imagine, and 0 is being dead, or worse if there is such a thing for you, what is your number?"

- **Preferences for care:**
  "Have you thought about what you would like to happen if you became very sick? Perhaps you have already prepared a living will."
  "Could you share with me some of your thoughts about these matters?"

See Modules 32 and 34 for interview strategies that assist with discussing and establishing care preferences.

---

**Clarify Values and Care Preferences**

Making good medical decisions depends on effectively helping patients and caregivers clarify their values and share their thinking with you.

Effective medical decision-making is a mutual process between doctor, patient and caregiver, and clinicians who assure that it is an open process within which each party shares thoughts and values about what is important and what should be done strengthens trust among the parties. Module 32 stresses that values discussions provide better guidance than asking about specific interventions such as chemotherapy, ventilators, feeding tubes or resuscitation. Modules 9-11 cover details about the complex process of finding the right decisions.

Ask direct open-ended questions to elicit values, such as,

- "What do you seek from your medical care?"

Also, review hypothetical scenarios to enhance mutual understanding. This might sound like,
"If you became really ill, would you prefer to minimize medical intervention to be as comfortable as possible, and die in 6 months, or would you prefer to go through uncomfortable treatments so that you might live a few months longer?"

CHALLENGES: COMPLEX COMMUNICATIONS

In this “challenges” segment, we discuss how cognitively impaired patients’ need for autonomy affects clinician decisions about communications. In addition, collaborative conversations with caregivers must support patients’ independence while maintaining confidentiality. Clinicians must balance patients’ interest in autonomy and independence against considerations of patients’ safety.

This chapter is divided into two sub-chapters:

- **Cognitive impairments and communication**
  Too often cognitively impaired patients are “left out” of medical decision-making as well-intentioned clinicians and caregivers plan for their safety. Optimize the balance (and resolve any conflicts) between your patients’ independence in decision-making on the one hand, and their safety on the other.

- **Caregivers and communication**
  Caregivers provide essential support for many older patients and are part of the care giving team. Communicate and collaborate with your patients’ caregivers while maintaining patient autonomy and confidentiality.

Strategies for communicating with cognitively impaired patients

Too often cognitively impaired patients are “left out” of medical decision-making as well-intentioned clinicians and caregivers plan for their safety. Optimize the balance (and resolve any conflicts) between your patients’ independence in decision-making on the one hand, and their safety on the other.

Medical decision-making is context-specific. Patients not capable of making decisions in some areas (e.g., safe driving) can possess decision-making capacity in others (e.g., timing or dose of medications). Patients who understand the options and consequences for a particular medical decision possess decision-making capacity in that context, even in the presence of underlying cognitive impairment. Assess cognitively impaired patients for decision-making capacity, and involve them in decision-making whenever possible.

When patients cannot make medical decisions or provide informed consent to them, make decisions with the caregiver in the presence of the patient. Then, periodically “check in” to gauge patients’ understanding and reaction to the options or recommendations under discussion.

When patients have severe cognitive impairment and are unable to report symptoms such as pain or depression, observe their behavior and work with and coach caregivers in detecting distress. Some typical signs of distress are sleep disorder, agitation and tense facial expressions. (7)

Driving Motor Vehicles
Driving carries tremendous symbolic importance about autonomy, and any conversation about driving threatens and frightens cognitively impaired patients.

Periodically review driving history with cognitively impaired patients and at least one observer. Initiate conversation about driving with the patient, and then include the caregiver. Taking the driving privilege away is fraught with distress, so act only on clearly observed and reported facts about deficits. If necessary, arrange for obtaining data from reliable observers.

Guidelines on when to restrict driving in patients with dementia are available for both clinicians (8) and families. (9)

States do not agree on uniform criteria for restricting driving. Become familiar with laws and regulations in your state regarding required testing and find out who can call for mandatory testing against the patient’s wishes (clinicians, family).

AnnotatedVideo (not shown in print-out text)

COMMUNICATING WITH HEALTH CARE PROVIDERS

Providing good care for older patients requires that multiple health care providers, usually including at least a clinician, nurse, and social worker, perform as a team, developing the ability to openly express opinions, feelings and conflicts, and agree on processes for resolving disagreements.

Quality care of older patients requires effective interdisciplinary teamwork. Conflicts may arise because team members on the one hand expect leadership from any clinicians involved, while on the other hand they value a flattening of hierarchy, and want clinicians to acknowledge the special expertise of team members. Many team members have little opportunity to practice skills that would help with negotiating such conflicts. Show that you respect the autonomy, the feelings and the ideas of other team members, and that you value their ideas and will strive to resolve any disagreements in a relationship-centered manner. Teamwork concepts are addressed in Module 38, and more specifically around the care of older patients in a "case study." (10)

- Help the team establish a clear, explicit understanding of the scope of authority of its members. This requires clinicians to learn more about the scope of expertise of members of other disciplines.
  - Will the social worker do the mental status and psychological assessments, but not the clinician?
  - Will the pharmacist change medication orders before or after checking with the clinician?)
  - Decide how disagreements will be resolved, including who will make the final decision to resolve disagreements.

- When offering assessment or recommendation to a practitioner from another discipline:
  - Routinely give your reasoning.
  - Provide evidence whenever possible.
  - Make it clear that you welcome being asked to provide evidence or reasoning for your opinion.
  - Use terms common to the two disciplines or explain unfamiliar ones. Clinicians routinely use a large number of abbreviated terms – CHF, DOE, PND, etc. Establish the habit of using the full term.

- When listening to practitioners from another discipline:
  - Begin with positive regard for practitioners and their opinion.
  - Understand the content clearly, asking for clarification when needed.
Inquire for reasoning and evidence.
Provide positive feedback.
Meet periodically to discuss process and problems in team function.

GERIATRIC ROUNDS

Working with acutely ill geriatric patients in the hospital often requires extra thoughtfulness, specific interviewing strategies and attention to your own and the patient's attitudes, values and goals of care.

In these next two videos, Dr. Williams and two residents work with a patient presenting a difficult challenge in care, drawn from a recent patient admitted to Drexel's medical service. The "patient" is Mary Cote, M.D., a retired pediatrician. In the third video a panel discussion with all the players and with Dr. Walter Cohen, Drexel's Chancellor Emeritus, addresses all aspects of the case.

- Video 1 shows the oral presentation
- Video 2 shows the meeting with the patient
- Video 3 shows a panel of experts who discuss all aspects of the case

Video is loading...

Brent Williams MD plays the Attending in this video.
Chileshe Nkonde MD and Lauren J. Van Scy MD are the Interns

AnnotatedVideo (not shown in print-out text)
AnnotatedVideo (not shown in print-out text)

BEHAVIOR CHECKLIST

1. Set a visit-specific agenda prior to visits, and elicit and negotiate the patient’s and the caregiver’s visit-specific agenda during the visit.

2. Ask patients whether they are comfortable, position yourself so they can see and hear you, and then check whether they can see and hear you.

3. Ask open-ended questions about living situation, functional status, outlook on life and preferences for care.

4. Ask patients about recent news, recent medical events, and a typical day.
5. Address patient initially, then address caregiver.

6. Build trust by explicitly including both parties.

7. Spend some of an initial visit alone with the patient, and do this periodically thereafter.

8. Build trust by routinely eliciting and incorporating patients’ and caregivers’ feelings, perspectives and values in diagnostic and management decisions.
9. Build trust by responding with empathic and respectful statements to patients’ and caregivers’ expressed feelings and values.

10. When alone, ask about violence.

11. Calibrate how much to include cognitively impaired patients in important decisions by checking their understanding of and reactions to the options under consideration.

12. Extend inquiry about both vague complaints and symptoms that patients seem to downplay.

13. Use the “brown bag” method to review patients’ medications.

14. Make appreciative statements that value caregivers’ work, and inquire about their stress levels.

15. Make appreciative statements that show that you value the expertise, autonomy and teamwork of other health professionals, and that show that you wish to maintain a climate of openness and respect in conversations with the team

REFERENCES


APPENDIX. ADDITIONAL REFERENCES; SELECTED ABSTRACTS

Abstract
PURPOSE: To test the assumption that knowledge, attitudes, and skills (KAS) in geriatrics are learned via exposure to elderly patients in nongeriatric clerkships. In the developed world, the proportion of adults > or = 65 years old will soon surpass the proportion of children <14. However, clinical clerkships containing geriatric rotations are not mandated by the Liaison Committee for Medical Education. METHOD: The authors assessed differences in geriatrics-focused KAS between medical students who completed a rotation in eldercare and those who completed a traditional nongeriatric clerkship. Over two academic years, the authors randomly assigned 263 clinical clerks to a clerkship year that did (elder care group) or did not contain a two-week rotation focused on geriatrics. All students completed questionnaires that assessed their knowledge of and attitudes toward geriatric patients before and after their clerkships. Before graduation, all students completed an objective structured clinical examination (OSCE) including a clinical station focused on geriatrics. RESULTS: Questionnaire and OSCE station response rates were 74.8% and 100%, respectively. The eldercare group had significantly higher knowledge scores (P = .004). Students' attitudes toward older adults worsened over the clerkship year in both groups, but slightly less in the eldercare group; that group had significantly higher OSCE geriatric station scores and overall pass rates (both: P < .001). CONCLUSIONS: Geriatrics is often regarded as a nonessential discipline. This study showed, however, that a clerkship year containing a specialized geriatric rotation is significantly more effective than a traditional clerkship year in preparing students to care for an aging population.
PMID: 20592520 [PubMed - in process]

2. J Am Geriatr Soc. 2009 Aug;57(8):1492-7. Epub 2009 Jun 25. A multimodal aging and dying course for first-year medical students improves knowledge and attitudes. Eskildsen MA, Flacker J. Division of Geriatric Medicine and Gerontology, Department of Medicine, School of Medicine, Emory University, Atlanta, Georgia 30329.
Abstract
When medical schools change their curricula, this opens up opportunities for the development of new material and often eliminates previously designed courses. Emory University's School of Medicine revised its curriculum in 2007, combining clinical medicine and basic sciences in the first 18 months. As part of its first section on "The Healthy Human," it included a weeklong module on aging. The main objective of this study was to evaluate attitudes and knowledge about aging issues before and after the course. The course included 5 days of sessions on topics ranging from molecular biology to societal aspects of aging.
Students completed a survey including demographics, the University of California at Los Angeles Geriatrics Attitudes Scale (UCLA-GAS), and the Facts on Aging Quiz-1 (FAQ1) before and after the course. The UCLA-GAS measures attitudes toward geriatric patients on a 5-point Likert scale, and the FAQ1 is a 25-item true-false test on knowledge of aging. All 130 first-year students completed the precourse survey, and 129 completed the postcourse survey. Four students said they planned to pursue specialty training in geriatrics before the module, and 10 planned to do so after the course (P=.28 using Fisher exact test). Mean UCLA-GAS score was 3.7+/-.4 before the class and 3.8+/-.4 after (P<.001 using paired t-test). Mean of correct answers on FAQ1 was 16.1+/-.2 before the class and 17.5+/-.3 after (P<.001 using paired t-test). This weeklong course on aging for first-year medical students at Emory improved their attitudes toward elderly people and their knowledge base on aging.

PMID: 19563520 [PubMed - indexed for MEDLINE]

Knowledge and attitudes about geriatrics of medical students, internal medicine residents, and geriatric medicine fellows.
Kishimoto M, Nagoshi M, Williams S, et.al.
Department of Medicine, John A. Burns School of Medicine, University of Hawaii, Honolulu.
Abstract
OBJECTIVES: To evaluate the attitudes and knowledge of medical students (MS1-3), internal medicine residents (postgraduate years 1 to 3 (PGY1-3)), and geriatric medicine fellows about elderly patients before implementation of a new geriatrics curriculum. DESIGN: Cross-sectional study. SETTING: An academic medical center. PARTICIPANTS: Two hundred eleven people participated: 54 MS1, 52 MS2, 50 MS3, 20 PGY1, 12 PGY2, 12 PGY3, and 11 geriatric medicine fellows. MEASUREMENTS: Each participant completed a questionnaire, including a 16-item geriatrics attitude scale, and a 23-item knowledge test (both revised versions of the University of California at Los Angeles (UCLA) Geriatrics Survey). Pearson correlation coefficients and t tests were used for statistical analyses. RESULTS: Both surveys demonstrated high internal consistency (alpha=0.70 and 0.71, respectively). Knowledge test scores increased with advancing level of training. MS1 and MS2 scored significantly lower and fellows scored significantly higher than others. PGY3 scored significantly higher than PGY1 on the knowledge test. All groups demonstrated positive attitudes toward geriatric patients (score>3.5). MS1 and fellows had significantly more favorable attitudes scores than more advanced students and residents. CONCLUSION: The results suggest that the UCLA Attitudes Scale and Knowledge Test can be used reliably to assess attitudes and knowledge level across all levels of medical education and training. The information from this study will be used to implement a more structured and comprehensive geriatrics curriculum across all trainee levels to improve attitudes and knowledge in the care of the geriatric patient.
PMID: 15667384 [PubMed - indexed for MEDLINE]

Older adults are less accurate than younger adults at identifying symptoms of anxiety and depression.
Department of Psychiatry, University of California, San Diego, CA 92093-9111.
Abstract
The present study examined age differences in the identification of anxiety and depressive symptoms in a community sample of 374 adults, ages 18 to 93. Older adults were less accurate and more likely than younger adults to label symptoms as neither anxiety nor depression. Both older and younger adults were more accurate in their classification of depressive than anxiety symptoms. These findings suggest that additional efforts are needed to educate the general public, particularly older adults, about anxiety and its symptoms.
Welcome to DocCom Module 24: "Tobacco Intervention"

by Michael G. Goldstein, MD, Margaret Dundon, PhD, and Susan Swartz, MD, MPH

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Michael G. Goldstein, MD, Margaret Dundon, PhD, and Susan Swartz, MD, MPH
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patients: Tom Fitzpatrick, Kate Hunter
Rationale
by Michael Goldstein, MD

The Patient's View

The Doctor's View

Questions for Reflection:

1. When and how should clinicians invite discussion of tobacco use?
2. How do you feel about patients who smoke, or try to quit and relapse quickly?
3. What strategies have you used (or seen others use) for successfully changing a habit or ingrained behavior?
4. What feelings come up when patients advocate for continuing to smoke or become defensive about quitting?

Key Principles:

1. Most smokers would like to quit, and respectful communication of an intention to address tobacco use enhances patient trust, motivation and confidence.
2. Use of conviction and confidence scales to calibrate readiness to change fosters patient engagement and collaboration.
3. Effective and satisfying interventions are tailored to patients’ beliefs about the importance of
4. Research shows the effectiveness of brief interventions using 5 A’s counseling principles - Assess, Advise, Agree, Assist, and Arrange.

5. Clinicians who apply the 5 A’s principles and skills can assist patients who are not ready to quit, those who are ready to quit, and those who have relapsed.

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe why tobacco dependence is a chronic and relapsing disorder.
- Use the importance and confidence scales to assess patient readiness to quit smoking.
- Describe, employ and adjust counseling skills that help patients who are uncertain about quitting, ready to quit, not ready to try or relapsed.
- Increase the likelihood of treatment success by tailoring dialogue and treatment planning to patient beliefs, prior attempts and present readiness.

**INTRODUCTION**

Smoking is the # 1 preventable cause of mortality in the U.S. Clinician treatment of tobacco use is straightforward and cost-effective.

Clinician intervention for tobacco use and dependence is one of the most cost-effective interventions in health care. (6, 7)

All clinicians play an important role in influencing and helping smokers to quit. Additional evidence shows that training community providers who are not professionals to briefly counsel smokers promotes quitting behavior. (3, 19)

Demonstrating to providers that quitting is not an “event”, but a stepwise “process” is a primary training goal. Just as smokers need to view temporary abstinence as a definite success, clinicians must recognize that a skillful and brief intervention can change patients’ attitudes and behaviors.

**Public Health Service Guideline**

Strong evidence supports the U.S. Preventive Services Task Force recommendation that tobacco intervention be a top clinical priority.

Smoking causes cardiovascular and respiratory disease, and also complicates chronic conditions and pregnancy. The 2008 U.S. Public Health Service (PHS) Clinical Practice Guideline (CPG) for Treating Tobacco Use and Dependence comprehensively reviews the evidence and concludes that brief advice - even less than 3 minutes - increases quit rates. (7)

A dose-response relationship exists between intensity of treatment and quitting. Further, treatment that includes both behavioral and pharmacologic interventions is more effective than
either element alone. However, even brief interventions are effective. The PHS CPG details evidence for effective treatments: pharmacotherapy (i.e., nicotine replacement, bupropion, varenicline), and practical counseling that may include problem-solving skills training and social support. (6, 7) Motivational interventions are also recommended for tobacco users who are not ready to quit. The full PHS CPG can be found at: http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html

---

**Quitting, an Arduous Journey**

Because smoking is a chronic and complex behavior with multiple determinants, achieving abstinence is arduous, both for patients and for the clinicians who seek to help them quit.

Tobacco use is woven into the fabric of a person’s life. Smokers think regularly about quitting; they want to change, but strong physiological, psychological, and social factors impact on whether they will reach for another cigarette. Change is sometimes abrupt - for example, after a heart attack. Most of the time, however, quitting is a challenging process, and abstinence requires that a smoker not only eliminate nicotine dependence, but also cope with living without tobacco. The process is strenuous, iterative and fluctuating – with repeated cycles of abstinence and resumption of smoking before achievement of stable abstinence. Hence, tobacco dependence is a chronic remitting and relapsing disorder, similar in this regard to asthma, heart failure or depression. Patients’ quest for abstinence sometimes seems impossible.

As with any chronic condition, successful clinician intervention depends on appropriate assessment, a trusting relationship and skillful informing and advising of patients. When abstinence is elusive, effective clinicians maintain a long-term perspective, continue to partner with patients in a patient-centered way and discern strategies appropriate for the particular individual.

Productive and satisfying patient interactions arise when clinician and patient focus on realistic goals that “meet smokers where they are”. (16) Clinicians who intentionally support patients’ exploration of feelings, obstacles and options can significantly shorten the abstinence quest. (6, 7)

---

**Obstacles**

Several serious obstacles negatively affect patient encounters and often block progress toward quitting - including the myths described below.

Click the links below to learn about myths that hold professionals back:

1. **Myth #1: Smokers don’t want to quit**
   Fact: many smokers would like not to smoke, although fewer are ready to try at any given moment.

2. **Myth #2: Smokers can quit if they really want to**
   Fact: long-term abstinence requires more than just an attitude or desire or “willpower.”

3. **Myth #3: Smoking treatments don’t work**
   Fact: randomized clinical trials show that effective therapies such as behavioral counseling, medications, social support (from a clinician as well as from others in the individual’s social network), and repeated interventions increase quit rates, and long term abstinence.
**Myth: No Desire to Quit**

FACT: most smokers would like not to smoke, and about half of them attempt to quit in any one year.

“Smokers don’t want to quit”, expresses clinicians’ belief that smokers have little desire to quit. The belief is partly based on many smokers’ statement that they enjoy smoking. The myth may also derive from the complex and often negative or painful dynamics of working with chronic behavioral conditions in medical settings. Data show that at about 70% of smokers want to quit smoking, and almost half make a serious attempt to quit each year. Of those who make an attempt, 4-7% are successful. (13) A clinician encountering smokers 2 or 3 times in a year may erroneously assume they have been continuously smoking, when in fact they have made one or more quit attempts during this period.

**Myth: No Willpower**

Fact: long-term abstinence requires more than determination or “willpower.”

Clinicians can effectively treat nicotine dependence, and should work with smokers just as they would manage patients with any complex, chronic or intractable condition. Smokers constantly hear that cigarettes are a bad ‘habit’ that can be ‘kicked’ any time. As a result, patients frequently lament, "I know it’s bad for me, I guess I don’t have the willpower to give it up." This false line of thinking gives smokers total responsibility for quitting. The patients are participating in "blaming the victim," in this case themselves, the victims of an addictive process. Nicotine is a powerful psychoactive drug, and smoking produces both psychological and physiological dependence.

**Myth: No Effective Treatment**

FACT: randomized clinical trials show that effective therapies include counseling and medications, and that repeated interventions increase quit attempts as well as long term abstinence.

Patients frequently bemoan their sense of failure and frustration, saying, "I tried the patch, and it didn’t work," or, "I did what you said, but I picked up again at a party." Without a “magic bullet” for tobacco use, it is no wonder that health professionals share patients’ lack of confidence about treatment. After any given encounter, even when competent clinicians counsel patients and employ the most effective treatments, only a minority achieve sustained abstinence. Clinicians begin to doubt their own competence as well as patients’ motivation, and then find that their own motivation to intervene decreases. But data presented in the PHS CPG clearly show that most smokers who use combinations of therapies will achieve at least temporary abstinence, and that short periods of abstinence can be leveraged to increase patient and clinician commitment and confidence to try again. (6, 7, 21)
BRIEF INTERVENTION

Short structured smoking interventions can be applied every day in the course of usual patient care.

Successful approaches are patient-centered and collaborative recognizing both the complexity of nicotine dependence and the slow process of behavioral change. A brief intervention for tobacco dependence can be delivered in any medical setting, including during a telephone call. Designating an intervention as “brief” implies that the tobacco discussion takes only a few minutes, not that the interaction is ineffectual or insufficient.

Tobacco dependence interventions derive from models of brief health behavior change counseling as well as patient self-management counseling for other chronic conditions, such as diabetes and obesity. (8, 31) The use of appropriate skills to address smoking is not associated with longer visits. (6, 7, 11, 19) The 2008 CPG includes a Quick Reference Guide for Clinicians. (7)

Research shows that both patients and providers report greater satisfaction when providers discuss smoking cessation, emphasize preventive care and discuss behavior change. (26)

Clinicians frequently discuss tobacco use, but less often offer assistance for quitting. (6, 7, 28) Simple explanations for this discrepancy include lack of provider skill and competing demands during visits. However, more insightful study shows that clinicians’ fears that smokers will become irritated and “difficult,” when added to the myths cited above tend to curtail discussion. But the facts debunk the myths, and clinicians can build trust that minimizes irritation and supports effective discussion.

Video is loading...

Brief Intervention

Introduction by Michael Goldstein MD

Communicate Concern

Directly state interest in patients’ context, conflicts and beliefs, and withhold admonitions.

Patients who smoke are sensitive to criticism, given the rise in cigarette taxes, smoke-free policies and public health programs that target tobacco use. Smokers expect to be admonished by friends, co-workers, family and health professionals.

A judgmental question such as,

"You were just in the hospital with a heart attack - haven’t you quit smoking?"

feeds into this expectation, heightens defensiveness, puts patients on guard and erodes their confidence.

An empathic alternative would be to state,

"I’m interested in hearing how things went with your smoking after the heart attack."

Even better, listen carefully while reviewing the interval history, as many patients will bring up smoking, which allows the clinician to respond supportively, strengthening the relationship upon
TOBACCO DEPENDENCE

Nicotine addiction is common and withdrawal of nicotine a powerful stimulus to pick up another cigarette. The more “hooked” one is, the more intensive treatment should be.

In this section you find more in-depth information about:

- **Nicotine**
  Nicotine’s combination of stimulant and depressant effects, its quick uptake by brain tissue and its subtle but very irritating withdrawal effects produce addiction that is difficult to break.

- **Intensifying treatment may help those who are more dependent**
  Ability to achieve sustained abstinence and to avoid relapse correlate roughly with intensity of dependence and relevant medical co-morbidity.

Nicotine

Nicotine’s combination of stimulant and depressant effects, its quick uptake by brain tissue and its subtle but very irritating withdrawal symptoms produce addiction that is difficult to break.

Nicotine reaches the brain less than 10 seconds after inhalation and achieves maximum concentrations within 1 minute. Nicotine has both stimulant and depressant effects that contribute to its addictive properties. Nicotine’s almost instantaneous entry into neurons, in combination with its effects on brain function optimizes conditions for the development of physical dependence. Acute (minutes and hours) and chronic (weeks and months) tolerance to nicotine effects contributes to an increase in cigarette consumption, as people must smoke more to obtain desired effects. Learned or conditioned factors, genetics, and social and environmental factors contribute to dependence, but to a far smaller extent than the neurological effects of the drug. (35)

At least 50% of smokers trying to quit experience significant withdrawal symptoms. Withdrawal symptoms appear within two hours, usually peak after 24 to 48 hours, and typically last from a few days to four weeks. (10, 35) Craving, increased hunger, and dreaming about smoking can persist for months. For some smokers, especially women, concerns about weight gain may deter quitting or even motivate starting to smoke. Most smokers gain weight after quitting, generally fewer than 10 pounds, but there is a broad range with as many as 10 percent of quitters gaining as much as 30 pounds (Fiore 2008). Women tend to gain more weight than men when they quit smoking. Suggestions for addressing post-cessation weight gain are included in the CPG. Effective pharmacotherapy for managing nicotine withdrawal reduces symptoms of withdrawal, increases quit rates, and may delay post-cessation weight gain.

Treatment Intensity
Achieving abstinence and avoiding relapse correlate with intensity of dependence and relevant medical co-morbidity.

Studies show that smokers more dependent on nicotine have greater difficulty quitting than less dependent smokers. (18) The Fagerström Tolerance Questionnaire measures dependence; in an office setting, a brief Heaviness of Smoking Index can estimate the degree of dependence from answers to two questions:

- How soon after you wake up do you smoke your first cigarette?
- On average, how many cigarettes do you smoke per day?

Certain types of smokers require more intensive interventions – usually a combination of behavioral strategies and medication. Individuals smoking within 30 minutes after arising, or smoking 25 or more cigarettes per day have higher levels of dependence. (9) Individuals who have not been able to get through 24 hours of abstinence in the past may require longer active treatment. Psychiatric co-morbidity such as anxiety and mood disorders, other substance abuse disorders and schizophrenia is associated with higher prevalence of smoking and more difficulty achieving abstinence from tobacco use. Relapse after quitting is common, and in randomized trials of pharmacotherapy, rates approach 80%. These findings support the need for a consistent, well-integrated and tailored approach to treating tobacco use and dependence.

Certain medical conditions may actually improve success with quitting. For example, quitting rates are higher among hospitalized patients undergoing coronary bypass or admitted for myocardial infarction. (22) Any condition that is directly related to tobacco use provides a “teachable moment:” an opportunity for clinicians to engage in personalized discussions about tobacco use and about the benefits of quitting. (6)

THE 5A's OF TOBACCO COUNSELING

Extensive research indicates that clinician use of the “5 A’s” helps patients quit. In addition, skillful “basic” communication, pharmacotherapy, assistance with problem-solving and skill-building for patients contribute to success.

The CPG, Public Health Service Clinical Practice Guideline (7) features the 5 A’s framework for counseling patients about smoking cessation (Table 1). The U.S. Preventive Services Task Force’s Counseling and Behavioral Interventions Work Group recommends the same framework for counseling about health behavior change. (8, 31, DocCom Module 16) The 5A’s emphasize motivational and educational needs, collaborating with patients to choose goals that are realistic and appropriate and tailoring counseling interventions accordingly.

Table 1: The 5 A's [Modified from (7)]

1. Assess - identify and document tobacco use status for every patient at every visit, and assess past behavior, motivation, importance and confidence;

2. Advise - quitting, and personalize to patient’s health status and concerns,

3. Agree - on goals and methods, based on willingness to quit

4. Assist - with a tailored plan that addresses barriers to quitting and accords with patients’ willingness to quit

5. Arrange - follow-up

In addition to 5 A’s counseling, the PHS Guideline recommends that tailored treatment plans
include the following:

- Recommend an approved pharmacotherapy regimen
- Encourage both counseling and medication
- Problem-solve with patients and teach them skills that help with quitting;
- Help patients access “quitlines” or more intensive treatment programs

When you focus interview time on addressing tobacco use, your interaction differs in important respects from other interviews, but also contains many familiar elements. New skills relate to assessing motivation/ready to change, and importance and confidence about change. In this DocCom Module, we show how small modifications of the essential communication skills of gathering information, (Module 8) understanding patients’ perspectives, (Module 9) and sharing information (Module 10) converge in the 5 A’s Model.

The 5A framework fits well with other behavior change models proven effective in enhancing smoking outcomes, including the Transtheoretical Model of Change (20), Social Cognitive Theory (2), Self-Determination Theory (32) and Motivational Interviewing. (17)

In the following sections, we describe the 5A’s approach to Tobacco Counseling, providing examples of the skills for each “A”.

**Assess**

The dialog below demonstrates guiding discussion, asking permission, and using open-ended questions and reflections to begin an assessment. Prepare for a “no” answer when asking permission.

Start by guiding the conversation to smoking and tobacco use. Specify your intention to help the patient to modify health risk behaviors. For example, you might begin with,

“I would like to talk with you about health behaviors and how you can modify these to promote good health. I noticed on the health history form you completed that you smoke.”

Pause here and allow patients to share something spontaneously about their smoking, providing implicit permission to go on. If they don’t speak, ask permission to continue the discussion, such as,

“Would it be OK to talk about your smoking and how it may be affecting your health?”

Asking patients’ permission to proceed gives patients control and helps minimize resistance to change. Once patients say YES, they at least agree to consider how smoking affects their health. When asking permission, however, be prepared for patients to say ‘NO’. Though rare, if it happens, you can respectfully reflect disinterest with,

“Seems like you are not willing to talk about smoking today.”

Sometimes this simple reflection opens the door to further discussion. However, if patients reiterate their wish to avoid a discussion, you can say....

“Ok, though I hope you will be willing to talk about it sometime, because stopping smoking is the single most important thing you can do to reduce your risk for future illness.”

Once permission to proceed is granted, use open-ended questions to learn about the patients’ smoking history, beliefs about smoking and its health effects, and their conviction (importance) and confidence about quitting. Use reflective listening to state the meaning of what you heard,
pausing to allow the patient to verify, correct, refine or add more information. The following dialogue demonstrates elements of an initial assessment:

**Doctor:** "So I noticed from your history form that you smoke?"

**Patient:** "Yeah…I know I should give them up.......it is not good for my breathing."

**Doctor:** "So, you’re aware smoking is having a negative impact on your asthma...you have been thinking of giving them up."

**Patient:** "Yeah, I’d really like to give them up.....my wife would like me to also....it’s hard to think about getting through the day without them. I’ve cut down to about a pack a day, though....I used to smoke 2 packs.

**Doctor:** "I am glad to hear that you know quitting will help us to better manage your asthma and make your wife happy. Sounds like you have worked hard to cut down, but are concerned about how you would manage without cigarettes.

**Patient:** "I have never been able to quit...I think I’m pretty addicted..”

**Doctor:** "So you think you are addicted to cigarettes based on your difficulty quitting. Sounds like you have tried....what was that like?"

**Patient:** "Well, I used some nicotine gum...but it bothered my teeth and gums.....so I gave it up after about a week and went right back to smoking."

**Doctor:** "That must have been frustrating. Yet, you managed to stay quit for a week?"

**Patient:** "It was more like 5 days....."

**Doctor:** "Well that is an accomplishment!"

**Patient:** "I never thought of it that way....but I guess you are right. I’d never gone more than a day without cigarettes before."

---

**Employ Relationship Skills**

Most patients are reluctant to dialogue about their smoking. Build safety by using core relationship skills such as reflections, affirmations, empathic statements and statements that normalize (“legitimize”) patients’ experience.

The example dialogue above shows the utility of open-ended questions and requests, and the clinician also uses a series of effective reflections to confirm data, allowing patients to add and refine their views regarding smoking. Note the affirmations (“I am glad to hear”, "you have tried", "that was an accomplishment") and the use of empathic statements (“you are concerned”...“that sounds frustrating”).

These relationship-building skills are vital elements of successful interventions whether or not the patient is right now ready to quit smoking. The statements assure patients that you are concerned but not judgmental and facilitate their disclosure of more information about their feelings and beliefs, as well as their attendance to your recommendations. (17)
Assess Motivation to Quit

Assessment of motivational readiness or stage of change improves clinician effectiveness by enabling them to tailor interventions to patients’ readiness.

Many smokers are interested in stopping tobacco, but only some are prepared to take action to quit. Clinicians are most effective when they adjust their dialogue to match patients’ readiness to change.

The Stages of Change model posits that change is a process of moving through several stages, not a sudden “event”. (20) A smoker in the stage of precontemplation has no interest in quitting in the foreseeable future. A patient in contemplation is ambivalent about quitting and not willing to make a commitment to change. Someone in preparation intends to quit within the next month, or has made recent changes in smoking behavior, and a smoker in action has recently quit and is using strategies to remain abstinent. Those in maintenance have quit for at least 6 months. Relapse to smoking is a frequent and entirely normal occurrence, and smokers should be re-assessed to determine motivational readiness at this time.

Limiting clinician intervention to persuading, lecturing about harms, or recommending action strategies is never effective and is frustrating for you and the patient. In contrast, tailoring interventions, for example, by reviewing information on smoking’s effects on their health to increase contemplative patients’ awareness is both more effective and more satisfying. (See the Agree and Assist sections below for more details on tailoring).

Assess Importance and Confidence

Assessing importance and confidence creates exploratory dialogue. Asking “why not a lower number” encourages additional disclosure of beliefs and knowledge. The explorations facilitate tailoring of advice and assistance.

Importance is what patients believe about the value or importance of giving up cigarettes. Confidence, also known as self-efficacy, is what patients believe about their ability to quit despite obstacles. Gathering information about importance and confidence helps to define smokers’ readiness for change, and allows you to tailor the “advise” and “assist” steps. You can use a numerical rating scale to clarify patients’ beliefs about value and ability.
The following demonstrates how to use the conviction ruler to assess a young woman’s motivation to quit smoking:

**Doctor:** “I would like to turn our attention to your health behaviors. What about smoking?”

**Patient:** “I’m still smoking……but I have cut down to less than a pack a day.”

**Doctor:** “I am glad to hear that you’ve cut down.” At this point, how convinced are you that it is important to quit smoking, say on a scale of 0 – 10, where 0 is not at all important and 10 is extremely important?”

**Patient:** “Right now?”.

**Doctor:** “Yes”

**Patient:** “Hmm…I would have to say about a 5.”

**Doctor:** “OK, a 5….so somewhat important. What led you to say 5 and not lower?”

**Patient:** “Well I know smoking is making my sinus condition worse……and you have told me repeatedly about all the other problems it can cause.. it’s just so hard to think about not having my cigarettes.”

**Doctor:** “So, you understand several reasons why quitting smoking would be beneficial. You would have fewer sinus infections and less chance of developing other serious medical problems, including heart disease and cancer. Anything else that led you to say a 5?”

**Patient:** “Well, I am hoping to get pregnant in the next year or so. I know smoking would not be good for my baby.”

**Doctor:** “You seem well informed about the risks of smoking during pregnancy.”

**Patient:** “Yeah…and so is my husband! He has been on my case as well.”

**Doctor:** “So, he’d be happy if you quit.”

**Patient:** “That’s for sure!”
**Doctor:** "What would it take for you to feel it was even more important to quit smoking?"

**Patient:** "I guess if I knew I would be able to do it....as I said, I don’t know how I would manage without my cigarettes."

**Doctor:** "So you are worried about getting by without cigarettes. Tell me more about what you mean."

In this example, the clinician learns about the patient’s beliefs. The questions, "What led you to say 5 and not 1 or 2?" and "what else?" elicited her reasons for quitting - she made her own argument for change! This technique, called eliciting “change talk” increases the likelihood of change (17). The basic relationship - building statements of reflection and affirmation allowed the patient to state her own ideas, moving seamlessly to the open-ended question that begins deeper exploration of the patient’s confidence about quitting.

Typically, the assessment would continue with, "On the same 0-10 scale, how confident are you that you could quit for a month?“ and follow with, "Tell me, what gives you the strength to say '5', and not 0 or 1?" which again is likely to elicit “change talk,” this time about the patient’s strengths. (Note that asking "Why are you not higher than '5'?” results in patients’ talking about their limits, not their strengths. Addressing barriers is important, but it is better to begin with strong points. DocCom Module 16)

---

**Advise Quitting**

Whenever you discuss smoking, include at least brief advice or information, asking permission to do so and personalizing it. Never lecture, and “roll with resistance.”

Evidence shows that even very brief advice increases quit rates. (7) Enhance giving of advice by personalizing it based on assessment of patients’ symptoms, risks, readiness, values and concerns. Be vigilant that “brief advice“ does not morph into lecturing and persuading, which always feels like attack or criticism to patients, and increases resistance and barriers to success. This is particularly so for smokers with low importance regarding quitting.

When assessment shows a low level of readiness to quit, ask permission to briefly offer advice or information. Patients rarely say “no” and the act of asking supports autonomy and increases patients’ receptivity to the advice. Be willing to accept a ”no”, a difficult prospect for many health professionals. After a “no” response, you might add a reflection, for example, “Sounds like you don’t want my input right now.” This simple reflection is an example of rolling with resistance, a tactic that helps avoid the unproductive, resistance-augmenting path of argumentation or persuasion. “Rolling with resistance” sometimes elicits patient “change talk” that reflects movement towards considering quitting.

Consider the example below:

**Clinician:** “So, you are not considering quitting smoking right now. Would it be ok if I shared my thoughts about how stopping smoking will benefit your health?”

**Patient:** “To be honest, ....no...I don’t want any lectures .”

**Clinician:** “So, you don’t want to hear my advice right now.”

**Patient:** “Well I know all about that scare stuff. I know smoking is not good for my health. I don’t need you to tell me that. again.”

**Clinician:** “I hear you. Sounds like you are already aware of the downside of smoking.”
Patient: "Yes......Listen, I know you are trying to do your job and I appreciate your concern......I am just not ready to quit smoking."

Clinician: "OK.....well, you are ready...I'm here to help you."

Patient: "Sure....maybe after the holidays."

Clinician: "That would be great."

In this example, asking permission and using simple reflections led to the patient’s own expression of a reason to quit, "I know smoking is not good for my health" and even some interest in quitting in the future! The clinician responded to this “change talk” with affirmation, and wisely, did not extinguish the patient’s small move into change territory, respecting the patient’s “no” response and not giving further advice or recommendations.

When advice is subsequently shared, personalize the advice by making links to improvements in health and well-being that the patient is likely to experience in the short-term or to other hopes or interests. See APPENDIX for Timetable of Benefits associated with quitting smoking.

---

**Agree: Basics**

Following “Assess” and “Advise”, engage in collaborative discussion in order to “Agree” with patients about goals and next steps.

Patients’ active participation of in a goal-setting process is associated with improved outcomes in studies of dietary, alcohol, and diabetes self-management counseling. (8) Collaborative goal-setting is a decisive determinant of successful tobacco interventions, and too often absent from clinician-patient encounters. Time that spent seeking agreement on clear and realistic goals is time well used. The interview goal is to collaboratively agree on specific outcomes by a specific time (such as the next visit) that are both desirable and achievable. (DocCom Module 11)

The outcome goal patients agree to choose often falls short of abstinence now and forever- the most healthful outcome. As an informed health professional, you may have difficulty “settling for less” than optimal goals. However, remembering that patients are in full control of their actions may help you to relinquish trying to control or mold their agenda. Giving up trying to shape their agenda helps lower patients’ resistance, and increases likelihood of making progress toward optimal outcomes at a later time. When patients are not willing to agree to quit, consider “motivational” interventions (below). If they are ready to quit, move on to the “Assist” step.

---

**Agree: Strategies**

Use relationship skills to help patients clarify and ascertain their own goals. Realistic and achievable goals will then be aligned with patients’ importance and confidence.

Create a collaborative process by reviewing and clarifying patients’ goals, articulating your clinical goals, and then finding common ground or negotiating a compromise. Show that you have heard patients’ perspectives by making statements that legitimize their beliefs, thoughts and feelings (DocCom Modules 6, 9). This empathic stance helps patients trust that you seek to collaborate with them in establishing sensible goals.
Ask patients to suggest goals and then jointly determine which ones are specific, realistic and aligned with their readiness, importance and confidence. Assure that you and patients agree on goals that are based on patients’ past experiences. Agreeing on an achievable goal is far better than persuading patients to assent to an “optimal” goal which they neither want nor are capable of reaching. A sensible goal encourages small successes instead of big failures and enhances the likelihood of successful change.

When smokers have little intention to quit, a sensible expectation is for them to notice their thoughts and actions around smoking, a suitable aim at this “no intention” stage. For such patients, you might state, “Should you become more interested in trying to quit in the future, I am ready to support you and talk about the best treatments available.” (And, see more detail in Table 2, below).

For smokers ambivalent about change (contemplating), a sensible expectation for the encounter is to reflect on their beliefs and to provide information that might increase the likelihood that the patient will consider quitting in the future. Reframe previous quit attempts as learning opportunities - sources of data about barriers and steps to success that can increase patients’ confidence in future attempts to quit.

Many smokers believe they must “quit on their own.” Thus, a sensible goal for those preparing to quit might be to discuss why various medication and counseling interventions help. Most patients have no idea that their “willpower” can be augmented by receiving advice and nonjudgmental support from clinicians.

When smokers are clearly ready for a quit attempt, a typical encounter goal is to offer counseling and medication integrated into a quit plan.

Table 2 provides examples of encounter goals and related messages that are adjusted to readiness.

### Table 2. Tailor messages to goals for the encounter. (27)

<table>
<thead>
<tr>
<th>If Patient Reports...</th>
<th>Goals for Patient Encounter</th>
<th>Examples of Messages</th>
</tr>
</thead>
</table>
| Not ready to quit smoking | Think about quitting       | "Quitting smoking can be difficult."
|                       | Praise prior attempts       | "What do you like about smoking?"
|                       | Examine reasons for smoking | "Is there any reason you might think about quitting in the future?"
|                       |                             | "It sounds like you’re not thinking about quitting right now. If you want to talk about your smoking any time, please let me know." |
| Wants to quit but not ready right now | Enhance desire to quit | "Tell me about any time in the past you tried to quit smoking."
|                       | Praise prior attempts       | "It’s understandable that you have mixed feelings about smoking."
|                       | Help him/her identify benefits to quitting | "Is there anything in particular that might motivate you to try and quit?"
|                       | Legitimize the challenge    | "There are better methods to help you quit now than ever before."
| Ready to quit now     | Develop treatment plan     | "It’s important to set a quit date."
|                       |                             | "Getting added help such as medications or counseling can really increase your success." |
Set a quit date. Counsel briefly. Offer medication. Refer for intensive counseling if appropriate. Follow-up.

*Recently quit* Maintain abstinence. Review ways to avoid slips. Identify social supports.

*Recently relapsed* Re-assess motivation. Praise attempt at quitting. Turn feeling of failure into small success.

"What are your plans if you get cravings for cigarettes?"
"We need to talk or meet again, I want to see how you’re doing."

"You should feel proud of yourself."
"Are others supporting your efforts?"
"Is there anything we can do to help you stay off cigarettes?"

"You should feel good about trying to quit."
"Any time you’re ready to try again, we are ready to help you."
"What might you do different next time?"

Check out the video example on the left where Michael Goldstein shows a 4 minute intervention.

In the example below, the clinician begins dialogue about realistic goals.

**Clinician:** "So, to summarize, you tried to quit smoking several times in the past, and were able to go without smoking for about a week. Once when you used nicotine patches, you had fewer problems with cravings. Right now, you’re thinking about quitting again."

**Patient:** "I am frustrated about my smoking, but also about my weight. I think I need some more help to be successful."

**Clinician:** "OK. I’m hearing that you might try to quit again, but don’t want to gain weight."

**Patient:** "Right. I can’t afford to gain 20 pounds."

**Clinician:** "What are your thoughts about what you would like to do now?"

**Patient:** "Well, I would like to quit. I read there are pills to help you quit, and not gain weight."
Clinician: "It's great that you're considering another try. Several medications can help increase success with quitting while limiting weight gain, and we can review medication options as well as talk about other strategies that might help limit weight changes when you're not smoking?"

Patient: "That would be great."

Clinician: "So, you’re ready to quit smoking, and you are willing to take medications and consider other ways to limit weight gain after quitting."

Patient: "Yes, I'd like to try using medicine, and I am willing to consider other options.

The clinician summarizes the assessment data and clarifies the patient's readiness. The patient desires to quit smoking and wants treatment that will help limit weight gain. The clinician makes empathic statements, reflects the patient's concerns about weight gain and expresses willingness to help address that barrier. Their collaborative process of reaching goal agreement sets the stage for the next element of 5 A's counseling, Assisting the patient to develop a specific plan.

---

**Assist: Quit Strategies**

The “Assist” process builds upon the output of first three A's – Assess, Advise and Agree. Collaboratively develop a plan for quitting for smokers who are ready for action.

For smokers who are prepared to try to stop, collaboratively identify a “stop date” - preferably within a few days or a week and develop a quit plan.

Begin to assist patients with **high importance** but **low confidence** by praising their decision- this supports autonomy. Affirm past small success and appreciate patients’ traits or attributes that you perceive as strengths- this supports self-efficacy. Designing a feasible plan works best when patients identify strategies themselves. Ask patients,

"Based on your experience, what problems do you foresee when you try to not smoke?"

Listen, reflect their concerns, and then ask,

"What ideas do you have about overcoming such challenges?"

Identify what went wrong after a period of success and brainstorm what else could be put in place to achieve a more durable result.

If patients have few or no ideas, offer your own. Seek strategies that enhance confidence. You can offer self-help materials, medications to reduce withdrawal, and information about local in-person programs and telephone quit lines. Explore potential supports in patients’ family and social network. Enlist the clinical team to teach specific coping and self-management skills. Office staff can provide support with brochures, internet resources, referral information, and can arrange follow-up.

Clinician: "You’ve set a date to quit. Can you tell me - what challenges do you see for you when that quit day gets here?"

Patient: "Well, I don’t have much trouble not smoking at work. You have to go outside the parking lot, or sit in your car – and I don’t like doing that because I smell like smoke. But when I get home, it gets pretty tough."

Clinician: "It's not convenient to smoke at work, and that supports your success during the day. When you get home, that's another story. What is it about being at
home that makes it hard?”

**Patient:** “When I come home, I want to relax and unwind, and smoking helps me do that. I usually watch the news and have 2 or 3 cigarettes then.”

**Clinician:** “So, smoking and watching TV go together after work. What about last year, when you told me that you quit for a month – what did you do after work?”

**Patient:** “Well, it was easier then because I lived with my boyfriend, who didn’t smoke, and we spent time together, took walks, cooked dinner…”

**Clinician:** “OK, last time you quit, you were able to distract yourself at home. What could you do this time?”

**Patient:** “I could spend more time with my daughter and call friends on the phone.”

**Clinician:** “I wonder if these same challenges will happen on the weekends, too? Would it be helpful if you could write a list – right here – about some ways to distract yourself outside of work.”

(Jointly the clinician and patient brainstorm a list).

**Clinician:** “…any other challenges you can think of?”

**Patient:** “Well, I seem to do OK for a week or so, and then I have trouble concentrating.”

**Clinician:** “I’m glad you mentioned this. Trouble concentrating is a common symptom of nicotine withdrawal. It sometimes can last as long as a month. Treatment can help: including medication to reduce those symptoms, or counseling or coaching by a tobacco treatment specialist.”

**Patient:** “Do you mean a stop smoking class?”

**Clinician:** “That’s one option. Another is a quit line, a free telephone program that helps many smokers get through the day and succeed at quitting. They call you back several times to see how things are going.”

**Patient:** “I’ve heard about the quit line, but I can’t imagine getting what I need by phone.”

**Clinician:** “Many of my patients had the same reaction. They tried it and found that it was a big help. Would you be willing to give them a call? I can have our nurse write down the contact information.”

**Patient:** “I guess I could.”

**Clinician:** “Ok, sounds like you have a plan. Can you just summarize for me?”

**Patient:** “Sure…let’s see… I’m going to list some activities to distract myself at home, like talking with my daughter. And I’ll call the telephone smokers’ line.”

**Clinician:** “Great. I’d like to see you or speak to you in a few weeks.”

---

**Assist: Nicotine Dependence**
Design treatment plans that take account of nicotine dependence level and quitting history. Assure that plans align with patients’ confidence level before making final decisions.

For patients with **low levels of nicotine dependence** and both high importance and high confidence (more than 7) provide brief, supportive messages and offer medication therapy.

Patients who relapse after a trial of nicotine replacement therapy (NRT) might try a non-nicotine medication or a medication combination. Reframe relapse after a period of abstinence as a success in order to dispel patients’ typical notion that the medication “failed to help.” Combinations of different forms of NRT or combination NRT and bupropion is more effective than monotherapy. (7) Use the quit experience as a starting place to determine whether alternative treatment plans are likely to prove more effective.

Assess patients’ confidence about their ability to carry out a new plan before providing closure. If their confidence is less than 7, success is less likely, and reasonable strategies in this situation include working to identify and resolve barriers until confidence is at least 7, or renegotiating and agreeing on a plan that patients believe they can achieve with confidence of at least 7.

In contrast, smokers with **high levels of nicotine dependence** are at high risk for relapse, *despite high confidence*. An initial step would be to prescribe higher doses of NRT or combination medication. Concurrent counseling through state-funded or health plan telephone services is helpful and programs are now widely available.(34) Do not hesitate to offer highly nicotine dependent patients more intense behavioral therapy, either in the office or with a professional tobacco specialist.

---

**Assist: Not Ready to Quit**

For patients who reject the idea of change, suggesting change options is an impolite waste of time. Check out whether patients feel hopeless. Respond with empathy, and roll with resistance.

Very low importance and very low confidence can be loosely equated with feeling “helpless and hopeless.” Patients need both high importance and at least modest confidence before you and they invest energy on changing. Few “helpless and hopeless” patients would be able to agree on a change goal, so pushing them towards active quitting steps is fruitless, frustrating and erodes trust. Steadfastly refrain from trying to persuade them to believe something or do something that is either not very important to them, or about which they feel hopeless.

Seek to comprehend their low level of importance by using the “rulers” as a starting place to elicit the pros and cons of changing or, using the confidence ruler, problem-solve with them about why they feel they cannot succeed. Listen attentively to their experience, responses, perspectives and feelings. Talk about the importance ruler:

> "What makes it a 1 and not 0” or even, “Zero...that’s as low as you can get...what would have to happen to make it a 1?”

You might find an opportunity for an **affirmation**, such as

> "So, you realize that there are some potential benefits to change”.

**Legitimize** the challenge for patients by reflecting on how hard it is to quit smoking. When providers say,

> "Sounds like it’s been tough for you quit,”
patients’ struggle is validated. They also hear something that says – ‘I’m listening to you’. Show that you wish to understand by reflecting back statements or the content of questions or objections.

Oh, because your boyfriend does not want to stop, it is hard to imagine trying.”

“I hear you saying that never being able to go beyond a day or two makes you feel hopeless, and stuck at a “1” on confidence”

This kind of reflection is called “rolling with resistance”, and research shows that it often (not always!) encourages patients to think more broadly, to examine pros and cons, to trust you more, and to value and invest in the relationship. At the very least, accurate acknowledgement of their situation helps them keep coming back for more conversation instead of feeling resentful about your unwillingness to meet them where they are.

After aligning with patients’ perspective, you can make simple recommendations that communicate your concern and expertise. Provide some feedback and information (from one sentence to many exchanges, depending on patient responses) so patients know that you think quitting is important. This might involve your wish to improve their heart condition or minimize risks for lung disease. Ask smokers to pay attention to their smoking behavior and discuss their feelings with you at a following visit. Recommend brochures or online resources (such as www.ahrq.gov or www.cdc.gov) or talking with people who have quit. More information on these skills can be found in modules on promoting behavior change, alcohol disorders, diet and exercise, and substance abuse (DocCom Modules 24,25,29,30).

Note that it is not “giving up” to mindfully loosen your natural urge to forge ahead, it is acknowledging the complexity of helping relationships. With respect to behavior change, outcomes are entirely dependent on patients’ actions. Clinician-patient communication and other actions may influence outcomes, but only patients fully determine outcomes. Aligning yourself with patients is the best way to create new opportunities for finding common ground.

AnnotatedVideo (not shown in print-out text)

Assist: Relapse

Help patients who relapse to combat their shame and hopelessness and stay engaged with change. Provide empathic support and additional information, reframe the relapse as a learning opportunity, and brainstorm solutions to barriers.

When patients quit, relapse within a few days is commonplace because nicotine withdrawal symptoms provide strong impetus to smoke, and smoking provides instant relief (it feels miraculous). Looking at relapse’s positive aspect, it demonstrates adherence to the quit plan and is an opportunity to reassess.

Reassess motivation, provide more information about nicotine withdrawal, and explore feelings and supports. Patients become discouraged and disillusioned when their dependence is high and social supports for behavior change are inadequate. Your compassionate statements and optimism will build relationship and trust. Then you will be able to explore importance and confidence again, and promote patients’ continuing engagement in the process of change.

AnnotatedVideo (not shown in print-out text)

Arrange: Follow-up
Arrange personal or telephone follow-up for patients in any stage of readiness, in order to check results, celebrate successes and review potential changes in importance or confidence.

Patient follow-up is an essential aspect of the smoking intervention, whether contact is face-to-face or by telephone. Follow-up is important even for patients who are not ready to quit. Brief advice, even during a single encounter, may tip the balance, and some smokers go on to make lasting change. For smokers attempting to quit, at least four contacts appear optimal for achieving sustained abstinence. Follow-up visits can be brief. (7) Assess treatment response, adjust medication and continue to provide supportive messages for quitting. The effective support technique of proactive telephone counseling can be conducted by clinical staff or a community resource.

Continuation of medications may be appropriate after a relapse, if patients agree to set a stop date soon to resume abstinence. However, if assessment suggests patients are not motivated to develop a new quit plan, discontinue the therapies. Schedule a future reassessment and consider a new treatment plan.

Strategies for providing closure to visits and arranging follow up can be found in DocCom Module 12.

AnnotatedVideo (not shown in print-out text)

CONCLUSION

Clinician intervention for tobacco use and dependence is one of the most cost-effective interventions in health care. Counseling intensity correlates with quit rates, and even brief advice – less than 3 minutes – increases quit rates.

The 5 A’s approach (Assess, Advise, Agree, Assist, Arrange) is a useful way to organize and customize tobacco use counseling and can be applied effectively for all patients who smoke, including those not ready to commit to quitting. Expressing empathy and building a trusting relationship are keys to successful 5 A’s counseling. Assessing patients’ readiness to change, including calibration of both the importance they assign to quitting, and their confidence about quitting enables clinicians to adjust, tailor and customize counseling interventions so as to increase overall effectiveness.

When smokers are not ready to quit, examine their “pros” about change, use reflective listening, provide empathic support and agree on a goal short of quitting – for example to reflect about their smoking experience. When patients are ready to commit to quitting, review past experiences and collaboratively choose among various evidence-based treatment options, potentially including medications. When smokers relapse after trying to quit, affirm successes, re-assess their importance and confidence about quitting, consider more intensive forms of counseling and more intensive pharmacologic treatment and agree on a new goal based on their current readiness.

Patient-centered, respectful and tailored 5A’s counseling, when combined with evidence-based pharmacological and behavioral treatments, not only enhances outcomes of tobacco dependence treatment but also increases satisfaction for both patients and clinicians.

RELEVANT BEHAVIORS

PREPARE
• Guide dialogue to smoking, and specify interest in discussing smoking to improve patients’ health
• Ask permission to engage in dialogue about smoking

ASSESS

• feelings and knowledge about quitting smoking
• importance or value patients attach to quitting, using a 0-10 scale
• patients’ confidence in their ability to quit, using a 0-10 scale
• patients’ beliefs and context (and show interest by reflecting back beliefs)

ADVISE

• Ask for patients’ permission to talk about advice
• Advise patients, providing personalized recommendations and information based on symptoms, risks, values and concerns

AGREE

• After elicitation of patient goals, sharing of clinician goals and affirmation of a collaborative partnership, agree on goals that are adjusted to patients’ readiness

ASSIST

• For all patients, express explicit respect for their autonomy and choices, affirm any "change talk" they express, and ask permission to make recommendations

[Modify additional “ASSIST” behaviors according to readiness and “Stage of Change,” as follows:]

• No interest in quitting soon ("Pre-contemplation")
  • Express concern for patients’ health, recommend that patients consult brief information (pamphlets or telephone quit line), and recommend that they consider writing down thoughts and feelings about smoking (diary)

• Some interest in quitting, but not ready for action ("Contemplation")
  • Review patients’ pros and cons about smoking and quitting
  • Review (briefly) potential actions for future consideration (trial of quitting, obtaining more information from reading or telephone quit line, adding medication)

• Sufficient interest to take steps toward quitting ("Preparation/Determination")
  • Check patients’ readiness to set quit date, and if ready set a date
  • For patients who set quit date, recommend options (pharmacotherapy, behavioral strategies, clinic or community based programs and support)
  • For patients not ready to set quit date, identify realistic steps, such as cutting down, switching brands, talking with supporters
  • For all patients, check for potential problems and brainstorm solutions

• Demonstrated interest – patients who have quit ("Action” or “Maintenance”)
  • Celebrate success and affirm desired behaviors
  • Elicit details about any lapses and potential threats or temptations
  • Reframe lapses as opportunity to identify and address triggers
  • Brainstorm and problem-solve methods to resist lapses

• Very interested, but resumed smoking ("Relapse")
  • "Normalize / legitimize" both the relapse and associated feelings (such as guilt, etc)
  • Celebrate successes prior to relapse and affirm desired behaviors
  • Explore details of relapse situation and elicit lessons patients learned
  • Brainstorm and problem-solve methods to resist lapses
  • Encourage and recommend trying again and, if ready, establish quit date and develop
new plan

ARRANGE

- Confirm agreement on details of action options
- Confirm future clinician availability and interest in patients’ health
- Arrange follow-up and referrals

LITERATURE REFERENCES


APPENDIX: Assist Conversations

Assist Strategies According to Readiness to Change: Not Ready to Quit

- Assess importance of quitting and patient’s confidence in quitting
- Elicit the pros and cons of quitting
- Listen respectfully to statements of resistance (or commitment) to change, and reflect them back to patients
- Empathize with patient’s perspectives and feelings about smoking and quitting
- Accept and express respect for patient’s choices
- Do not attempt to persuade a “not ready to quit” patient to quit smoking

Assist Strategies According to Readiness to Change: Ready to Quit

- Assess patient confidence about quitting and their past experience with stopping
- Identify and agree on a specific stop date
- Examine barriers and brainstorm ways to overcome them
- Collaboratively choose options for treatment. Include counseling, and medication when appropriate
- Arrange specific follow-up to review patients’ experience with quitting
Assist Strategies According to Readiness to Change: Quit and Relapsed

- Empathize with feelings about slips and relapses (Legitimize the struggle)
- Affirm any success toward quitting
- Re-assess patient conviction and confidence about quitting
- Identify specific triggers to slips or relapses
- Collaborate to identify strategies to address triggers
- Identify and set a new quit date
- Arrange follow-up to review the patient experience with quitting

APPENDIX: Benefits of Quitting Smoking

Benefits of quitting smoking begin within minutes and additional benefits build over the years. It’s never too late to benefit from quitting. (American Lung Association)

**20 minutes after quitting**
- heart rate drops

**12 hours after quitting**
- carbon monoxide levels in blood drops

**2 weeks-3 months after quitting**
- circulation improves and lung function improves

**1-9 months after quitting**
- coughing and shortness of breath decrease
- cilia (tiny hair like structures that move mucus out of lungs) regain normal function that helps to clean lungs and reduce risk of infection

**1 year after quitting**
- excess risk of coronary heart disease is half that of a smoker

**5 years after quitting**
- risk of stroke is reduced to that of a nonsmoker after 5-15 years

**10 years after quitting**
- Lung cancer death rate about half that of continuing smokers.
- Rates of cancer of mouth, throat, esophagus, bladder, pancreas and cervix decrease

**15 years after quitting**
- risk of coronary heart disease is equal to that of a nonsmoker
Welcome to DocCom Module 25: Motivating Healthy Diet and Physical Activity

by Geoff C. Williams, M.D., Ph.D.

Credits:
Authors: Geoffrey C. Williams M.D., Ph.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized Patients: Robin George
Clinician on camera: Geoffrey C. Williams M.D., Ph.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

3.1 - 8/6/2014 update of hyperlinks
3.0 - 1/19/2012 Enhanced with HTML5 code and MP4 videos
Rationale
Geoffrey C. Williams, M.D., Ph.D.

The Patient's View

The Doctor's View
Geoffrey C. Williams, M.D., Ph.D.

Questions for Reflection:

1. What concerns do you have about discussing nutrition and physical activity with patients?
2. On a scale of 1 – 10, how confident are you that you can help your patients adopt healthy eating and exercise habits?
3. How do you feel when your patient says “I can’t change my diet” or “I don’t have time for healthy daily physical activity?”
4. How confident are you that you can balance your own diet and physical activity to optimize your health? Consider why you are not more confident, and then why you are not less confident?
5. What would you need from your own clinician to learn to maintain healthy diet and physical activity?
6. How do your attitudes about motivation nutrition and physical activity affect your counseling?

Key Principles:

1. Brief interventions by clinicians are effective at helping patients to improve nutrition and to
2. Human motivation is psychological energy directed at specific goals.

3. Negotiating reasonable goals, listening with empathy, non-judgmentally supporting patient needs, and believing that your patients can change helps patients to locate and sustain their motivation.

4. Changing eating and exercise habits requires that patients learn new information, intend to change, and persist at trial and error.

5. Most Americans need to reduce serving sizes and choose better quality foods. To do this we need to be able to:
   1. Read food labels
   2. Reduce portion size by about 25%
   3. Avoid trans fats
   4. Insure that half of daily grain intake is whole grain.
   5. Devote thirty minutes of physical activity per day at moderate levels to prevent chronic disease, 60 minutes per day to maintain a stable weight, and 90 minutes per day to lose weight.

---

**Learning goals:**

**At the conclusion of this module, you will be able to:**

- List evidence that good diet intake and daily physical activity promote health.
- Assess patients’ diet and daily physical activity, and recommend specifics of balanced energy intake and expenditure.
- Describe the rationale and evidence for using the 5 A’s intervention strategy
- Demonstrate ability to assess interest in behavior change, elicit patient perspectives empathically, and express support of patient autonomy.
- Negotiate healthy change goals for diet and physical activity, and respond positively to lack of success.

---

**BACKGROUND**

The topics covered in the first section of this module are:

- **Why should clinicians or health care practitioners do the counseling?**
  Over 300,000 premature deaths per year in the US are attributable to unhealthy diet and physical inactivity (1).

- **Always consider patient nutrition and physical activity together.**
  Despite major public health efforts, Americans are growing more obese, resulting in an increased prevalence of chronic illness. Unfortunately, fewer than a third of patients receive lifestyle counseling from clinicians.
Why should clinicians or health care practitioners do the counseling?

Over 300,000 premature deaths per year in the US are attributable to unhealthy diet and physical inactivity (1).

55-60 million Americans have prediabetes (2). People with impaired fasting glucose (IFG) and impaired glucose tolerance (IGT) often have obesity (especially abdominal or visceral obesity), dyslipidemia with high triglycerides and/or low HDL cholesterol, and hypetension. Structured lifestyle intervention aimed at increasing physical activity and producing 5-10% loss of body weight and certain pharmacological agents prevent or delay the development of diabetes in people with IGT (3).

More than one third of people born in the U.S. 2000 will get diabetes (Type 2) before dying (2). “Trans fats” are found in high percentages in U.S. foods (e.g., margarines and fast foods) and are a major cause of cardiovascular disease (3). Trans fats now appear on all food labels. Balancing energy intake that includes daily physical activity of 60 minutes at a moderate level (walking 3-4 mph) would dramatically lower rates of diabetes, cardiovascular disease, arthritis, obesity, and cancer.

Always consider patient nutrition and physical activity together

Despite major public health efforts, Americans are growing more obese, resulting in an increased prevalence of chronic illness. Unfortunately, fewer than a third of patients receive lifestyle counseling from clinicians.

The Dietary Guidelines for Americans 2005 provide evidence based recommendations to balance energy intake and expenditure in order to prevent major chronic diseases (e.g., Type 2 diabetes, several cancers-including colon cancer-, cardiovascular disease, osteoporosis, and degenerative arthritis) and to improve health and quality of life (6). American jobs have become increasingly sedentary, and Americans now are unlikely to expend enough energy during work to maintain physical fitness or a healthy body weight.

Over the past two decades portion sizes have increased dramatically (“portion distortion”- http://hin.nhlbi.nih.gov/portion/), and have left patients and clinicians unable to identify healthy serving sizes (7). Obese adults underestimated their daily caloric intake by 47%, and overestimated their daily energy expenditure by 51% even before this increase in portion size began (7). American adults gain an average of roughly 2 lbs per year (9). Together these “forces” have led the average American to become overweight or obese (60% of Americans), and to get inadequate amount of physical activity to maintain health (only 15 % are active at the recommended level, and 40% are sedentary). Yet, less than 30% of patients currently receive lifestyle counseling from their clinician (10). It seems that health care practitioners need as much motivating to do this counseling as patients need to make dietary and physical activity changes.

It is likely that clinicians are the most potent motivators of patient life-style change, based on studies of counseling about tobacco and alcohol. This is because clinicians have unique access to patients, and because patients solicit and respect clinician advice. Doctors have a greater impact on population health than any other single health practitioner (11,12,13). If health care systems assist clinicians to provide counseling and a second type of health care provider is involved, the counseling is even more effective (14).
COUNSELING PRINCIPLES

In this section, the following topics are covered:

- **Motivation**
  Motivation is energy directed at a particular goal. You can energize your patients by having positive relationships, supporting their autonomy and promoting self-efficacy.

- **Support of patient autonomy**
  Promoting patient autonomy, defined as patient willingness to engage in a behavior, is motivating, yields better health outcomes and is fully consistent with engaging patients in the process of informed decision making (8,19).

- **Physical activity and nutritional recommendations**
  As a clinician, you are an important motivator of change. Your patients will likely need to discuss change several times before trying to change and attempt change several times before being successful.

## Motivation

Motivation is energy directed at a particular goal. You can energize your patients by having positive relationships, supporting their autonomy and promoting self-efficacy.

The field of health psychology has several theories of motivation that inform practitioners how best to counsel patients to change behavior (11). Motivation has two components: psychological energy and direction. Clinicians need to account for both these components of motivation to provide effective counseling. The “direction” of motivation has to do with negotiating agreement with the patient on the health goal to be achieved. Thus, establishing clearly agreed upon goals for nutrition and physical activity becomes crucial to successful change. Psychological “energy” to reach those goals is felt to come from a variety of sources: positive relationships that support patients unconditionally, higher levels of autonomous self-regulation of the patients, and higher levels of perceived efficacy (or perceived competence).

Patients are likely to hear advice to change their behavior several times before they will begin efforts to change, and then are likely to try several times before they can maintain the change over time. There is a very strong dose response relation between amount of contact time and successful change in tobacco abstinence, yet even simple advice statements from clinicians increase abstinence rates 5 months later (14). It is likely that nutrition and physical activity counseling will also be more successful with greater contact time and with additional health care workers integrated into the support system (15). In this module, we recommend you spend 6-9 minutes on counseling for diet and nutrition, and physical activity, and repeat this counseling over time (16,17).

## Support of patient autonomy

Promoting patient autonomy, defined as patient willingness to engage in a behavior, is motivating, yields better health outcomes and is fully consistent with engaging patients in the process of informed decision making (18,19).

In addition, promoting autonomy is one of three fundamental principles of medical care (20,21).
Supporting autonomy serves as a clinical end-point for all health care encounters. Thus, not only is supporting autonomy associated with behavior change and better health, it is essential to providing ethical clinical care. Researchers identify seven clinician behaviors that support autonomy, and reduce the likelihood the patient will interpret the recommendations as controlling.

These behaviors include:

1. Elicit patient perspectives before making recommendations (e.g. listen actively).
2. Acknowledge patient affect related to the topic.
3. Negotiate health goals the patient is willing to pursue.
4. Identify and discuss effective options for change versus not changing.
5. Discuss the disorders caused by poor diet and inactivity.
6. Present effective treatments and lifestyle change options.
7. Discuss risks and benefits of no treatment, and benefits and risks of treatment.
8. Provide your recommendations clearly and a rationale for change.
9. Elicit patient understanding and perspective regarding options.
10. Support patient initiatives for change. Recognize most people need to initiate change several times before they are successful.
11. Negotiate a plan, including a time table for determining if the course of action was effective.
12. Minimize control.

**Physical activity and nutritional recommendations from Dietary Guidelines 2005 and beyond**

As a clinician, you are an important motivator of change. Your patients will likely need to discuss change several times before trying to change and attempt change several times before being successful.

Clinicians need to be able to provide specific recommendations in a straightforward manner that patients experience as motivating, and not as controlling. Patients are more likely to change if clinicians initiate these discussions (22). Ongoing follow-up is needed because most patients are unlikely to change on the basis of a single discussion, and most patients will need to attempt change several times before being successful.

Key Recommendations from the Dietary Guidelines for Americans 2005:

1. Consume fewer calories to remain healthy.
2. Be more physically active to remain healthy and weight management.
3. Make wiser food choices to remain healthy.
4. Avoid trans fats (trans fats were added to food labels in 2006)

**THE WAVE AND REAP TOOLS**

The WAVE and REAP are validated for use in brief clinician discussions of nutrition and physical activity. The WAVE assesses weight, activity level, variety of intake and excess intake. The REAP assesses food intake. (17, 23, 24)

Assessment and counseling based on the WAVE and REAP is intended for general nutrition counseling, such as in the time typically allotted in primary care visits. If the patient has hypertension, the Dietary Approaches to Stop Hypertension (DASH) is recommended by the Diet Guidelines (6).
The PREMIER trial demonstrated that persons with hypertension can sustain multiple lifestyle changes that improve blood pressure control over 18 months (25). The DASH Eating Plan is available at http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf.

If the patient has complex problems, or is not able to make good progress in 3 to 6 months, then refer to a dietician for further assessment and counseling.

---

**The WAVE Tool**

The WAVE instrument can be downloaded as a double sided pocket guide at http://med.brown.edu/nutrition/acrobat/wave.pdf (17).

The WAVE has two sides; one for assessment, and the second for recommendations. Each side is divided into four quadrants related to each letter of the acronym. The assessment side is intended to answer the following questions:

- **Weight** - is the patient under or overweight?
- **Activity** - does the patient get enough physical activity to optimize health? To manage weight?
- **Variety** - is the patient eating a variety of foods from important sections of the food pyramid?
- **Excess** – is the patient eating too much?

The recommendations side is to be used to guide your counseling once those questions are answered. In order to assess whether the patient’s “variety” of foods meets nutritional standards, and to determine if the patient eats an “excess” of calories from a particular food group, the practitioner can complete a quick 1 day 24 hour food recall (estimated to take 3-5 minutes), compare foods eaten with the Food Pyramid recommendations, or complete the REAP with patients.

---

**The REAP Tool**

The REAP tool can be downloaded from http://med.brown.edu/nutrition/acrobat/REAP%206.pdf. Also, available at http://med.brown.edu/nutrition/acrobat/reapmdkey.pdf is the Clinician Key which aids the provider in discussing the patient’s answers and counseling them about recommended changes for each major dietary area.

Patients can complete the REAP (written at the 5th grade level) in the waiting room to shorten time (estimated 10 minutes). The intervention using the REAP is illustrated in this module.

Specifically, the REAP assesses intake of the following:

- Whole grains
- Calcium-rich foods
- Fruits and vegetables,
- Fat
- Saturated fat and cholesterol-avoid trans fats
- Sugary beverages and foods
- Sodium

The REAP also assesses whether the patient:

- Engages in regular physical activity
- Prepares his or her own food
- Has trouble being able to shop or cook
- Follows a special diet
- Eats or limits certain foods for health reasons
- Is willing to make changes to eat healthier
COUNSELING

In this section you'll find the following topics covered:

1. **The 5A’s**
   As a clinician, you should use 6-9 minutes of counseling for behavior change on physical activity and diet.

2. **Integrating the WAVE and REAP into the 5A’s Diet and Physical Activity Counseling**
   Regular counseling about diet and physical activity are needed for Americans to reach Healthy Goals for 2010 (26).
   - **ASSESS**, Weight
   - **ADVICE**, Activity
   - **AGREE**
   - **ASSIST**, Variety & Excess
   - **ASSIST**, Reduce Calories
   - **ARRANGE**

---

**The 5A’s**

As a clinician, you should use 6-9 minutes of counseling for behavior change on physical activity and diet.

This counseling is recommended for life style change as part of National Guidelines for Hypertension, Hypercholesterolemia, Diabetes and its prevention, Cardiovascular Disease, Physical Activity, and Obesity. The 5 A’s include: (see also DocCom module 16)

- **Assess**-background information regarding risk, behaviors, patient knowledge related to Physical Activity and Diet
- **Advise**-provide a clear advice statement personalized to the patient’s situation.
- **Agree**-negotiate whether the patient is willing to change and establish common goals. Use the conviction /confidence scale in M16 here to assess motivation and elicit positive statements of change.
- **Assist**-set a change date, establish a change plan, problem solve and skills build, and support patients obtaining extra-treatment support
- **Arrange**-Follow-up, establish a time frame for assessing effect of current plan

---

**Integrating the WAVE and REAP into the 5A’s Diet and Physical Activity Counseling**
Regular counseling about diet and physical activity are needed for Americans to reach Healthy Goals for 2010 (26).

As you are learning the specific content outlined below, please consider your own motivation for incorporating the 5A’s into your medical practice. You will need to adapt your office system to support your counseling practices. Most clinicians will need multiple change attempts to maintain using the 5A’s in practice. Gradual change in your practice is likely to be more successful than trying to master all of the material at once. The specific tasks needed to complete the 5A’s are outlined in the following paragraphs. Much of the content of the counseling has been adapted from Blackburn & Waltman (16) to fit the 5A’s format.

Mr. R. is a 49 y.o. advertising executive who has been very successful in his work. He is married with 2 children 14 and 17 y.o. He has a BMI of 31 (see http://www.nhlbisupport.com/bmi/bmicalc.htm) and his blood pressure is 132/84 in your office today. His total cholesterol is 198 with an LDL of 125 and fasting blood glucose of 101 mg/dl. You have been his clinician for 4 years, since he moved to the area and his weight has increased by 2-4 pounds each year. You are seeing him for a health maintenance visit.

Go the the next section using the tree-menu on the left or in clicking the section title below:

- **ASSESS**, Weight
- **ADVICE**, Activity
- **AGREE**
- **ASSIST**, Variety & Excess
- **ASSIST**, Reduce Calories
- **ARRANGE**

In these sections, the 5A’s and WAVE are indicated by those words in brackets.

**ASSESS, Weight**

**Doc:** “I am starting to place more emphasis on nutrition and physical activity in my practice. You can tell by the diet questionnaire (REAP) that you were given to complete while you were waiting for me. Would it be alright to spend a few minutes going over this with you now? I think its important for your health.”

**Mr. R:** “Sure.”

**Doc:** “I see that your weight has been increasing by a few pounds each year over the past few years. Your body mass index of 31 means that you are in the obese category.”

**Mr. R:** “Yes, my new position has kept me busy at work, I just don’t have time to get any exercise.”

**Doc:** : “Often times these promotions have their costs as well as benefits. Is this the most you have weighed?”

**Mr. R:** “Yes. It’s hard to resist all the food we have at our meetings. We encourage people to work through lunch by providing good food.”

**Doc:** "Well, you are experiencing what most Americans are-gaining 2-4 pounds per year,"
because jobs and diets like yours and mine no longer allow us to burn enough calories to maintain our health. What does it mean to you, learning that you are obese?"

**Mr. R:** “My wife has been after me to lose weight and to go on a diet.”

**Summary:**

1. Much of Assess has already occurred at other visits as you know his health history.
2. Mr. R has completed the REAP before your meet with him.
3. Ask permission to discuss his weight. If he says no, ask why, and when it would be OK to discuss.
4. Provide a diagnosis, as most obese people don’t acknowledge that they are obese.
5. Provide a rationale such as “most Americans are gaining …” to normalize.

---

**ADVISE, Activity**

**Doc:** “Of course, I’d advise you to be more active, and reduce your calories, too. However, I wonder if you could find any reasons that might be worth to make changes yourself. For example, your pattern of weight gain, higher blood pressure, blood sugar, and cholesterol may result in heart disease or diabetes over the next 5 to 10 years. What are your thoughts about this?”

**Mr. R:** “I don’t like the sound of having diabetes, or a heart attack.”

**Doc:** “It is hard to think about yourself having diabetes, or heart disease.”

**Mr. R:** “I’ve never really had any illnesses before. That would be a hard way to start.”

**Summary:**

1. Be clear about the risks of obesity, and personalize this to his risk profile if possible.
2. Elicit his perspective, and reflect what you hear the patient say.

**Sidebar:**

If the patient has a healthy BMI (see http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm) that is stable, and is otherwise healthy, your advise statement could be something like this:

“Based on what we have discussed, and your health history, I feel your health would be best maintained if you ate healthier foods and were physically active for 30 minutes of walking a day. By ‘healthier’ I mean you would be less likely to get diabetes, heart disease, and some cancers if you choose better quality foods and were physically active each day. I’d like to work with you on this if you are willing.”

Ask if the patient understands your recommendation, and for his perspective about what you have said. Answer any questions. Be prepared to acknowledge that this represents a big change.
**Doc:** "You can avoid these, but it is a reasonably difficult change. It takes at least 6 to 8 weeks to find out if you can really learn to live in a new pattern. How motivated are you on a scale of 1 to 10 to walk for 60 minutes a day, while you reduce your calories?"

**Mr. R:** "About 4."

**Doc:** "Tell me, what keeps you from being an 8"

**Mr. R:** "I just don’t have that kind of time in my day."

**Doc:** "What keeps you from being a 2 in motivation?"

**Mr. R:** "Well, I really would feel better about myself if I could lose about 30 pounds."

**Doc:** "Would you be willing to try for 5 to 10 pounds, first? Or, how about just trying to keep your weight neutral? There is a great deal of health you get from a 10 pound weight loss, or not gaining more weight, particularly if you become more physically active."

**Mr. R:** "Okay, I’d like to lose 10 pounds. What do I have to do?"

**Summary:**

1. After presenting the diagnosis of obesity and risk information, provide hope by indicating that the patient can be successful at changing the cause-energy imbalance. Acknowledge that it’s difficult to make these changes over the long term.

2. Use the motivational assessment of asking how motivated the patient is to establish a new lifestyle. Then, explore the barriers by asking: Why aren’t you higher than the number given? Write these in his chart so you can use these barriers to brain storm about these expected problems later. Now, move to agreement by asking: Why aren’t you lower than the number given? Patient is likely to answer with a personal (or autonomous) reason for change. If the answer isn’t about him, ask again “are there any other reasons that keep you from being less motivated?”
3. Negotiate a reasonable goal. Most patients want to lose lots of weight right away. This is likely to be frustrating to them later when most can’t maintain it. Suggest establishing new physical activity patterns or that just remaining weight neutral will be a success. This will help at future visits.

ASSIST, Variety & Excess

**Doc:** “I want you to try three things; be more physically active; reduce your calories by 25%; and, eat healthier foods. We will go over each of these briefly, but first I would suggest you choose a date to start in the next two weeks, if possible. What date makes sense to you?”

**Mr. R:** “Next Saturday.”

**Doc:** “Tell others around you that you are making these changes and ask for their support. Anticipate where you will have difficulties and plan around those.”

**Mr. R:** “I’ll tell my wife, she will be thrilled. I’ll ask her to go to the gym with me and to help change our diet. How much time do I have to exercise?”

**Doc:** “I feel the physical activity is the most important part for your health. I want you to do whatever you can to start a new pattern of daily physical activity that you can continue. I suggest 15 minutes a day of walking at 3-4 miles per hour for the first week, then increasing to 30 minutes a day in the second week. Further increases will depend on your weight goals. Do you think you can make room for this daily physical activity?”

**Mr. R:** “That will be a stretch, but I think I can do that by taking a walk after dinner.”

**Doc:** “Here are some general guidelines about physical activity that you can use to guide how much you do in the long run. 30 minutes a day of walking provides a lot of health by protecting you from diabetes, heart disease and colon cancer. The problem is you will likely still gain weight. 60 minutes of walking at 3-4 miles per hour will keep you very healthy and your weight neutral. Here’s the bad news, it takes 90 minutes a day of walking to lose weight for most Americans.”
Mr. R: "I can’t believe it takes so much time to lose weight. There is no way I can do that with my schedule. Does it have to be all at one time?"

Doc: “It does sound like a lot, but that’s because the portions we eat are way too large. No, you don’t have to do the physical activity all at once. You could do six 10 minute walks to keep your weight neutral. Every additional step improves your health, and burns calories, but it takes 20 steps to burn a calorie, that’s about an hour of walking to burn off one candy bar with 250 calories.”

Mr. R: SILENCE

Doc: “It seems daunting, doesn’t it-do what you can just walking over the next 8 weeks. Perhaps you won’t be able to make any change."

Mr. R: "Well, I feel I need to do something about this sooner or later, lets try now."

Doc: "Build up gradually adding 10 or 15 minutes of walking per day each week to get to your goal. If you want to exercise harder than that, it takes time, but I would like you to get a stress test first before you exercise vigorously. Then, I’d like to see you back and discuss what went well and where it didn’t. Try not to be hard on yourself. What would be a reasonable physical activity goal for you?"

Mr. R: “I’ll try to get to 20 to 25 minutes per day and see what happens."

Summary of physical activity assist:

1. Support any patient willingness to start being more active. Be positive about any commitment to change, and that you feel the patient can do this.
2. If he is not ready to change, ask what would make it important enough for him to change. Let him know you will bring it up again. Be positive, attentive and empathic.
3. Outline the three levels of activity and their relation to weight and health, either at this first visit or at the second. Be positive, acknowledge his reaction to this information.
4. Negotiate a date for the change to start.

ASSIST, Reduce Calories

Doc: “That would be a great start. The second thing I’d like you to do is to learn to read food labels, so that you know what and how much you are eating. I have an example label here for you. The most important things on the label are to understand portion sizes so you can reduce your calories and to avoid all trans fat-if possible-because they cause heart disease. Trans fats now appear on all food labels in the U.S.

In order to complete the next two parts of the discussion on reducing portion size and eating healthier food, first review the following information:

1. **Determine Patient’s Daily Caloric Needs**
   To quickly estimate the patient’s daily caloric needs you will need to know the patient’s age, gender, and whether they are sedentary, moderately active, or active.
2. **Understanding and Controlling Portion Sizes**
   In order to reduce caloric intake successfully, your patient needs to know how to read a food label and how to estimate a serving size.

3. **Behavioral Strategies for Weight Loss**
   Record your weight frequently, keep a food diary, monitor your daily physical activity pattern.

4. **Set specific goals**
   Set specific goals with your patients for the various food groups. Be sure to set realistic expectations.

---

**Determine Patient’s Daily Caloric Needs**

To quickly estimate the patient’s daily caloric needs you will need to know the patient’s age, gender, and whether they are sedentary, moderately active, or active.


A third resource for deriving a patient's caloric needs and fat intake is http://www.heart.org/HEARTORG/GettingHealthy/FatsAndOils/Fats101/My-Fats-Translator_UCM_428869_Article.jsp (27). After you enter your patient's, height, weight, age, gender, and physical activity level, the resource calculates caloric need, as well as recommended range for total fats and limits for saturated fats and trans fats.


---

**Understanding and Controlling Portion Sizes**

In order to reduce caloric intake successfully, your patient needs to know how to read a food label and how to estimate a serving size.

Ask your patients to look over a sample food label and whether they feel comfortable understanding it. Ask patients if they can identify one or two of the following serving sizes based on everyday objects. Some basic strategies from Blackburn and Waltman (16) include reviewing how to read a food label, and teaching the patient in the Assist Step to identify a portion size by comparing it to everyday objects he or she is familiar with.

Additional strategies to reduce portion size include:

- Leaving 25% of one's meal behind
- Taking 20 minutes or more to eat each meal
- Using a smaller dinner plate, and not letting foods touch each other on the plate
- Starting meals with appetizers of low energy density, such as salads and broth based soups
- Eating breakfast daily
- Adding fiber to breakfast
- Learning skills for managing portions when eating restaurant foods
Behavioral Strategies for Weight Loss

Record your weight frequently - Keep a food diary - Monitor your daily physical activity pattern

A recent study by Wing and Hill (28) found that patients who maintained weight loss of 30 lbs or more for a year engaged in very specific behaviors: weighing themselves weekly, eating breakfast daily, and being regularly physically active. Several recent studies have shown that daily self-weighing by participants was strongly associated with successful weight-loss maintenance and clinical guidelines from the National Heart, Lung, and Blood Institute emphasize the importance of regular self-monitoring for long-term maintenance (29).

Those who choose to eat healthier and get regular physical activity will need additional skills:

- To learn what a calorie is.
- To learn to read food labels.
- To learn to avoid trans fats.
- To learn about portion distortion, and how to gauge a serving size in terms of recognizable, everyday items such as a tennis ball or a deck of cards. Suggest the patient review the “portion distortion” website to learn more about this (http://www.nhlbi.nih.gov/health/educational/wecan/eat-right/portion-distortion.htm).
- To learn the physical activity needed to burn certain amount of calories (e.g., that it takes a 150 lb person about an hour of walking at 3.5 miles per hour to burn 250 calories- or the amount of calories in a candy bar).
- To learn about why they overeat and to find replacement activities that are healthy.

Set specific goals

Set specific goals with your patients for the various food groups. Be sure to set realistic expectations. The thrust of your recommendations is to have them move away from the typical American diet which is high in red meat, saturated fats, and refined flours to one that is rich in fruits, vegetables, whole grains, lean meats and low fat dairy products.

If they can’t agree in principle to the overall direction of change, it is best to know that now.

Review the REAP questionnaire with your patients. If agreeable, introduce each of these goals and ask if your patient is willing to make some change toward one or more of these goals working with you or with a nutritionist.

Choose quality foods:

1. Half of your intake of grains should be whole grains (e.g., 3 slices of whole grain bread)
2. Have 5 to 9 servings of fruits and vegetables (4.5 cups for 2,000 calorie diet)
3. Keep total fat between 20 and 35% of total calories, with most fats coming from fats such as fish, nuts, and vegetable oils; limit saturated fats, trans-fats, and cholesterol.
4. 3 cups per day of fat-free or low-fat milk or equivalent.
5. Consume less than 2,300 mg of salt (one level teaspoon) per day. Include potassium rich food.
6. Keep alcohol to no more than 1 drink per day for women and 2 per day for men.

Be physically active (e.g., walking at 3-4 miles per hour) for 30 minutes per day.
We return to the interview between Mr. R. and his clinician.

**Mr. R:** "I try to eat healthy foods, I just keep gaining weight."

**Doc:** "You filled out that questionnaire in the waiting room. I'd like to look that over with you, now. Were there any categories that you were interested in changing?.... You might pick one for this time and we can consider others at your next appointment."

**Mr. R:** "I would like to cut down my red meat, and I could do without one of the drinks I have each night."

**Doc:** "Those are both changes that can improve the quality of your diet and reduce your calories. Your body can only use 4-6 ounces of protein each day. The rest is converted to fat, and alcohol has no nutritional value. Perhaps that walk after dinner will replace your second drink. What do you think?"

*We have covered a lot of territory today. I will make some notes about your goals.*

**Summary - “CQE”:**

1. Cut calories
2. Choose Quality Foods
3. Exercise Daily

---

**ARRANGE**

**Doc:** "Do you have any questions or concerns about what we have covered?"

**Mr. R:** "No, I am sure my wife will be delighted."

**Doc:** "Bring your wife next time, if you would like. Remember to set modest goals you can live with. It is difficult to make long-term change all at once, but I have confidence that you can improve your health and reach your goals over time. I'd like to see you again in about 8 weeks, is that okay with you?"

**Mr. R:** "Sure"

---

**CONCLUSION**

Improve your patient’s outcomes related to diet and exercise by giving basic advice and utilizing strategies of proven effectiveness to establish personalized plans.
Provide basic advice to cut calories, choose good quality food, and exercise daily. Your strategies will focus on supporting motivation, assisting in skills building and assisting in getting additional support. First, support motivation. As a clinician, you can be an important motivator of nutrition and physical activity change. Begin with a collaborative discussion that includes evaluation of nutritional intake and physical activity. Be positive that your patient can change. On return visits, be attentive, respond to affect and remain empathic; if your patient has not been successful, acknowledge any frustration and remain non-judgmental. Identify any short term successes and indicate that most people need to try more than once to succeed. Suggest that your patient choose a specific date in the next 2 weeks to renew change efforts, and remind that you will continue to help.

Next, assist in skills building and problem solving. Spend the time to introduce to every willing patient the basic concepts of calories, reading food labels, serving size, and the health benefits expected from living in energy balance that includes 30 minutes of daily physical activity. Patients with medical problems requiring specific nutritional changes (e.g., hypertension, diabetes mellitus) should be directed to a more specialized diet (e.g., DASH for hypertension) and to a dietician.

Finally, assist in getting additional support. Ask your patient to bring important others to your visits, and advise your patient to discuss plans and ideas with friends, family and co-workers, and seek their support to make changes.

RELEVANT BEHAVIORS

- Emphasize energy balance (nutrition and physical activity) when counseling.
- Assess nutritional intake and physical activity for all patients (Consider WAVE and REAP).
- Explore the patient’s perspective before and after making clear recommendations for change.
- Support your patient’s initiation of any positive change he or she agrees to make.
- Avoid increasing resistance (examples: never argue; acknowledge that making no change is an option; never speak arrogantly.)
- Recommend 30 minutes of physical activity per day for all patients.
- Recommend 5 to 9 servings of fruits and vegetables for all patients.
- Refer patients with multiple dietary change needs and with specific medical problems to a dietician (in addition to your own counseling.)
- Recommend the DASH diet for those with hypertension or pre-hypertension.
- Express your certainty that your patient can succeed in making these changes.
- Arrange for follow-up in a reasonable time (1-8 weeks).

REFERENCES

Welcome to DocCom Module 26: Anxiety and Panic Disorders

by Steven E. Locke, M.D.

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Steven E. Locke, M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Standardized patients: Heidi Fergusson
Clinician on camera: Steven E. Locke, M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Rationale
Steven Locke, MD

The Patient's View

The Doctor's View
Steven Locke, MD

Questions for Reflection:

1. What are non-verbal clues, including your own subjective responses to the patient, that indicate the patient is anxious?

2. What concerns do you have about shifting your interview to allow for exploration of the patient’s past history of treatment for mental disorders?

3. What kinds of situations make you anxious? How might your own experiences with anxiety lead you to a greater understanding of patients with anxiety?

4. How do (or might you) feel when patients cannot be reassured that their physical symptoms are likely due to an anxiety disorder?

5. How might these feelings affect your communication with your patient?

Key Principles:

1. Patients with anxiety disorders are more likely to present with physical symptoms than to complain that they feel anxious. Take all somatic concerns seriously. Any attempt to dismiss their relevance will increase patients' anxiety. Anxiety can be "catching," so be careful to
approach anxious patients in a calm and reassuring manner.

2. Patients will be reassured that you are taking them seriously when you explore their somatic symptoms carefully, even when you think the symptoms are likely to be physical manifestations of anxiety.

3. After exploring somatic symptoms, transition gently to inquiring about current worries, concerns and recent stressors. Ask whether the patient has previously had similar symptoms, and/or treatment for an anxiety disorder or a mood disorder.

4. In addition, take a thorough history to discover whether the anxiety could be a sign of
   1. an underlying medical disorder (e.g., hyperthyroidism),
   2. an adverse drug effect (e.g., SSRIs, psychostimulants, respiratory medications such as theophylline, and steroids),
   3. toxic effects of caffeine or alcohol,
   4. an agitated withdrawal state due to alcohol or drug discontinuation, or
   5. an undiagnosed depressive disorder that is presenting with anxiety.
   6. an underlying history of trauma: rape, incest, sexual abuse, or exposure to violence

5. Because anxiety disorders can be familial, it is important to also explore the occurrence of similar symptoms in biological relatives and inquire if there is any family history of phobias, obsessive-compulsive behavior, panic attacks, agoraphobia, social anxiety or shyness. A family history of alcoholism or substance abuse is often a marker for underlying anxiety or mood disorders that may be familial.

6. In addition, anxiety disorders are often “co-morbid,” and co-occur with other mental disorders such as depression, post-traumatic stress disorder, and/or substance abuse. Look carefully for these diagnoses as well.

   **Tip:** A paper-and-pencil self-report symptom checklist or computer-assisted assessment tool can be very helpful in ensuring a more thorough evaluation than is otherwise possible in primary care or general medical settings.

---

**Learning goals:**

**At the conclusion of this module, you will be able to:**

- describe the key features of anxiety as it appears in its most common forms in the primary care setting;
- list common somatic symptoms that lead anxious patients to seek treatment in the general medical setting;
- list medical conditions that can masquerade as an anxiety disorder;
- elicit anxious patients’ symptoms and perspectives;
- assess the patient for comorbid conditions (behavioral and somatic);
- inform patients how mind-body interactions produce somatic symptoms;
- inform patients about treatment options, and explore their interest in treatment
INTRODUCTION

Despite a high prevalence of anxiety disorders, clinicians frequently miss this diagnosis. They fail to explore patients' current worries, concerns and recent stressors, and do not ask whether the patient has previously had similar symptoms, and/or treatment for an anxiety disorder or a mood disorder. Instead, clinicians focus on "ruling out" an exhaustive list of illnesses that "might" produce the patients' somatic symptoms, often ordering unproductive expensive studies.

Anxiety disorders are serious medical illnesses that cause disabling anxiety and fear. Unlike episodic anxiety caused by a stressful event such as a business presentation or a first date, anxiety disorders are relentlessly distressing, disrupting patients' lives with irrational fear and dread. Effective treatments are available, and research is yielding improved therapies that can help most people with anxiety disorders lead fulfilling lives.

Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, and phobias (social phobia, agoraphobia, and specific phobia).

1. In a given year, approximately 40 million Americans, about 18 percent of adults over 18 have an anxiety disorder.
2. Almost 75% of patients with an anxiety-disorder have their first episode by age 22.
3. Anxiety disorders frequently co-occur with depressive disorders or substance abuse.

Anxiety disorders are common in primary care, with prevalence about 15%. Primary care patients usually have relatively mild symptoms, and the anxiety disorder is often co-morbid with depression, substance abuse, or somatization. (2) Each anxiety disorder carries distinct features, but the common theme of excessive, irrational fear and dread binds them together. Most common, and most confusing to distinguish from medical disorders that produce symptoms of anxiety are generalized anxiety disorder and panic disorder. Currently, growing numbers of veterans from combat theaters of operation are re-entering civilian life; the appearance in primary care settings of patients with symptoms of PTSD requires a heightened alertness and proper diagnosis and treatment. Primary care clinicians less often encounter obsessive-compulsive disorder, social phobia (or social anxiety disorder), and other specific phobias.

In this module we will focus on the more common Generalized Anxiety and Panic Disorders. First, though, we will review the basic approach to anxiety in medical patients.

Physical or emotional?

Anxiety disorders are quintessential “mind-body” disorders that mock medicine’s outdated view of the mind and body as separate entities.

Distressing physical symptoms usually lead people with anxiety disorders to primary care clinicians. Particularly if symptoms such as dizziness, shortness of breath, palpitations, muscle tension, or sleep difficulties are worsening or recurrent, they mislead patients and their clinicians. In the frequent fruitless search for a “physical” disorder, clinicians overuse tests and procedures.
In the absence of skilled explanations, the unnecessary expense and negative results make patients more anxious and dissatisfied, and they worry that their frustrated doctors are thinking “the problems are all in your head.”

Of course, nothing could be further from the truth. The complex pathophysiology involves the brain and peripheral nervous system, the autonomic nervous system and both central and peripheral elements of the neuro-psycho-endocrine system.

This module enables you to discern when common physical symptoms belong to a medical condition that is masquerading as an anxiety disorder, and far more commonly, to discern when to provide specific treatment for the anxiety disorder in which distressing and disabling physical symptoms suggest an occult medical disorder. A principal therapeutic tool for anxiety disorder management is your skillful conversation that informs and encourages patients, that is not defensive about testing (or NOT testing!), that responds to patients’ perspectives, and that consistently shows your empathy and positive regard for patients.

Who should be assessed for anxiety?

Clinicians can address the dilemma caused by the disparity between the high prevalence of anxiety disorder and infrequent diagnosis by systematically employing simple and validated screening tools.

Anxiety disorders are so prevalent in primary care settings and so frequently undiagnosed that we recommend regular anxiety screening for every patient. This screening may occur annually during a well patient visit. It should also happen at any time a patient presents with physical symptoms that are not attributable to an obvious acute physical disorder. Particularly important are the following symptoms: sweating, shortness of breath, dizziness, palpitations, syncope, choking sensations, flushes, paresthesias, and even chest pain (especially in a young person with no risk factors for cardiac disease).

Many patients who are at a high risk of anxiety have other problems that divert attention and result in continued and increased suffering because of the untreated anxiety. Important groups include patients with chronic illnesses such as diabetes, heart failure, CAD, patients with unexplained somatic symptoms such as pain, fatigue, or neurological symptoms, and patients under stress because of major life transitions such as job loss or caring for a sick family member, or those with a recent exacerbation of a serious illness.

If you become concerned about an anxiety disorder during an acute care visit, use a brief standardized assessment tool to help you decide whether to follow up with a more detailed exploration.

Screening for Anxiety Disorders

Anxiety disorder screening can be done with either self-report or clinician administered screening tools, and each has its advantages.

When concern about an anxiety disorder surfaces during an interview, use a brief standardized assessment tool to help decide whether to proceed with further diagnostic explorations.

Patients accept the easily completed and accurate brief self-report assessment tools currently available, and we recommend that clinicians use them. One example is the GAD-7, which is discussed in detail in "Elicit Symptoms" section under "APPROACH", below. It asks about the 7 cardinal features of Generalized Anxiety Disorder (GAD), and has high sensitivity and specificity for
GAD. It is less sensitive, but fairly specific for Panic Disorder, Social Anxiety Disorder and PTSD. (11)

Pencil and paper versions are being replaced by versions for computer, telephone (interactive voice response systems IVR), on-line or smartphone usage. Clinician-administered tools require valuable time that is better used for dialogue with patients about the meaning of symptoms and for providing information about diagnostic and treatment options.

---

**WHEN A PATIENT IS ANXIOUS**

When a patient shows nervousness, whether verbally or non-verbally, or when a patient has multiple somatic symptoms not obviously connected to a medical problem, seek more information so that you can establish or reject the diagnosis of an anxiety disorder.

Take a careful history, listening for anxiety related to known diseases, and for possible medical conditions that can lead to anxiety. Gather information about medications, including herbals and OTC meds, and attend carefully to the psychosocial history. Ask about “stress” and listen actively, getting details of the stressful situation, the timeframe, and the patient’s emotional reactions. Ask about substance use and abuse, depressive symptoms, and past history of anxiety and panic attacks.

Check for family history of mental disorders, including substance use disorders. There is a high rate of heritability and comorbidity of anxiety and mood disorders(6).

---

**Anxiety in medically ill patients**

People who are medically ill often exhibit anxiety. Some of the numerous psychological reasons for this response include the following: (3)

- Uncertainty regarding the medical diagnosis and/or the prognosis
- Concern about one’s body (loss of function, disfigurement)
- Fear of pain or suffering
- Fear of death
- Fear of dependence
- Fear of abandonment
- Concern about the impact of illness on identity and livelihood
- Concern about the impact of the illness on relationships (family, friends, coworkers)
- Concern about interacting with strangers or being in the hospital
- Concern regarding negative reactions from clinicians
Co-morbid Depression

Depression often accompanies anxiety disorders (4) and, when it does, it needs to be treated as well.

Nearly half of patients with anxiety disorders also have major depression, and nearly half of patients with depression have an anxiety disorder. Symptoms of depression include feelings of sadness, hopelessness, changes in appetite or sleep, low energy, and difficulty concentrating (M 27). Most people with depression can be effectively treated with antidepressant medications, certain types of psychotherapy, or a combination of both.

Responding to anxious mood

Rely on basic rapport-building skills to respond to a patient’s anxious mood. Five basic skills have been discussed in Module 6: reflection, legitimation, support, partnership, and respect.

When a patient appears anxious, it is usually helpful to make a brief reflective comment, e.g.,

“You seem quite [tense][restless][nervous][anxious][upset]” (select a descriptive word that seems to reflect the patient’s experience). If the patient seems perplexed by your reflective comment, mention what you observed that led you to make the reflective statement. For example, you might say:

“Well, you’re fidgeting and restless and seem to be having a hard time concentrating on what we’re discussing. Is there something that’s distracting you? Can you tell me about it?”

A simpler approach might be:

“I can see this is upsetting for you to talk about.”

Usually this type of comment is helpful, but not always. Some patients with anxiety also suffer from shame sensitivity and may feel criticized or even humiliated by the clinician commenting on their obvious anxiety. In this instance, you will need to defuse the stigmatizing power of the observation by mentioning how common these symptoms are (“legitimize” the patient’s situation) and that by recognizing them early, effective treatment can be started.

Empathic comments about the observed symptoms serve many purposes – they let the patient know you are listening and observing. This gives the patient “permission” to talk about the feelings. And it communicates a sense of support to the patient. When you listen and respond empathically, sometimes the anxious patient will allow more of the associated sadness to emerge after hearing this type of facilitative comment. The patient’s eyes may even tear up or he/she may start to cry.

EVERYDAY ANXIETY DIFFERS FROM ANXIETY DISORDERS

Patients with Generalized Anxiety Disorder (GAD) have “free-floating” anxiety, characterized by an over-reactive nervous system whose reactions produce physical symptoms.
If someone pointed a gun at you, it’s likely that you would become anxious. Your heart would beat faster and could pound, your palms would become sweaty, breathing would become rapid and shallow, your mouth would become dry, and intestinal motility would decrease.* That is adaptive anxiety and a component of the “flight or fight” response described by Cannon. But what if merely pointing a pencil at you produced the same full set of responses? That inappropriate response would be an indication of the presence of an anxiety disorder – an over reactive nervous system easily triggered by otherwise neutral stimuli. Some people with those characteristics suffer from repeated and frequent elicitation of the flight or fight response and live with a chronic state of “free-floating” anxiety. Constant over-reactivity to everyday worries and concerns can lead to persistent physical and emotional symptoms of distress, and produce the condition known as “generalized anxiety disorder” or, GAD.

*Although sympathetic activation decreases colon activity, the colon has increased motility in panic attacks, which may be attributable to CRF.


**DSM IV Diagnostic criteria for generalized anxiety disorders**

- **A. Excessive anxiety and worry** (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

- **B. The person finds it difficult to control the worry.**

- **C. The anxiety and worry are associated with three (or more) of the following six symptoms** (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.
  - restlessness or feeling keyed up or on edge
  - being easily fatigued
  - difficulty concentrating or mind going blank
  - irritability
  - muscle tension
  - sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

- **D. The focus of the anxiety and worry is not confined to features of an Axis I disorder**, e.g., the anxiety or worry is not about having a Panic Attack (as in a Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

- **E. The anxiety, worry, or physical symptoms cause clinically significant distress** or impairment in social, occupational, or other important areas of functioning.

- **F. The disturbance is not due to the direct physiological effects of a substance** (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

AnnotatedVideo (not shown in print-out text)
Panic Attacks

Panic attacks are feelings of terror that strike suddenly and repeatedly with no warning.

People who have panic attacks can’t predict when an attack will occur and one result is that people develop intense anxiety between episodes, worrying when and where the next one will strike. When repeated panic attacks lead to persistent or recurrent worry about future attacks, the condition is known as panic disorder.

If you are having a panic attack, most likely your heart will pound and you may feel sweaty, weak, faint, or dizzy. Your hands may tingle or feel numb, and you might feel flushed or chilled. You may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. You may genuinely believe you’re having a heart attack or losing your mind, or on the verge of death.

Panic attacks can occur at any time, even during sleep. An attack generally peaks within 10 minutes, but some symptoms may last much longer. Lifetime prevalence estimates are almost 1 out of 4 persons for isolated panic attacks (without agoraphobia) and almost 1% for panic attacks with agoraphobia but without panic disorder (4).

Panic disorder

Panic Disorder is common, disabling and treatable. Suicide is a tragic outcome. Panic Disorder is frequently co-morbid with depression, substance abuse or alcoholism.

Panic disorder is a painful condition and associated with suicide, especially when accompanied by depression. This is especially tragic because the illness is one of the most treatable of the anxiety disorders, and very responsive to medications or targeted psychotherapy. Some people with panic disorder go for years without learning that they have a treatable illness. Many people with panic disorder visit an emergency room repeatedly or see a number of doctors before they obtain a correct diagnosis.

Panic disorder affects about 6 million adult Americans (1), about twice as many women as men (5), and in any given year about 2.7 percent of people over age 18 have panic disorder. Lifetime prevalence for panic disorder is almost 4% without agoraphobia, and just over 1% for panic disorder with agoraphobia (4). Panic disorder often begins during late adolescence or early adulthood (5), and the risk of developing panic disorder appears heritable (6). Not everyone who experiences panic attacks will develop panic disorder—for example, many people have one attack but never have another. Treatment for panic disorder is effective, but patients with untreated panic disorder can become very disabled and develop a secondary depression. Panic disorder is frequently comorbid with major depression, and when they occur together the depression treatment is more difficult and outcomes are poorer.

In addition to being frequently co-morbid with depression, panic disorder is often accompanied by other serious conditions such as drug abuse or alcoholism (7,8).

Video is loading...

Steven Locke, MD, is the Clinician in this video
### Agoraphobia

When people with recurrent panic attacks become unable to carry out everyday activities, their illness is called agoraphobia.

Recurrent panic attacks lead people to avoid places or situations where panic attacks have occurred. For example, if a panic attack strikes while riding in an elevator, a person might develop a fear of elevators. If she begins to avoid elevators, that affects her choice of a job or apartment and restricts other parts of her life.

Some lives become so restricted that people avoid everyday activities such as grocery shopping or driving, and some people become housebound. Others are able to confront a feared situation only if accompanied by a spouse or another trusted person.

Basically, people try to avoid any situation in which they would feel helpless if a panic attack were to occur. When their lives become very restricted, as happens in about one-third of people with panic disorder (5) the condition is called agoraphobia. Early treatment of panic disorder can prevent agoraphobia.

### Screening questions for panic disorder

The first two questions have 94% sensitivity to detect panic disorder if either is positive.

1. **In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy?**
   - yes___ no___

2. **In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn’t catch your breath?**
   - yes___ no___

   IF YOU ANSWERED YES TO QUESTION #1 OR TO QUESTION #2, THEN CONTINUE WITH QUESTIONS 3-5, OTHERWISE, STOP (0 = NO PANIC DISORDER).

3. **Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?**
   - yes___ no___

4. **How many times have you had a spell or attacks in the past month?** (Check one.)
   - Hasn’t happened at all in the past month
   - Once___ 2 to 3 times___ 4 to 10 times___ More than 10 times___

5. **In the past month, how worried have you been that spells or attacks might happen again?** (Check one.)
   - Not at all worried___ Somewhat worried___ Very worried___

CONDUCT A FULL ASSESSMENT

Full assessment of patients with anxiety includes 3 fundamental steps.

- First, build enough trust and relationship with patients so that they are willing to disclose their symptoms, while asking the screening and follow-up questions discussed above;
- Second, differentiate these symptoms from a general medical condition or adverse drug effect;
- And third, help patients to understand how anxiety can be the basis for their persistent or recurrent physical / somatic symptoms.

Facilitate acknowledgement and disclosure of anxiety symptoms

When you discover any symptoms of anxiety, continue with an open question, and move to inquiry about the 7 cardinal symptoms of Generalized Anxiety Disorder.

If patients show verbal or non-verbal signs of anxiety, you might make a reflective comment as a way of beginning your data gathering in an open-ended way. For example, “You seem worried (or nervous, or anxious.)” If the patient acknowledges anxiety and worry, ask them to tell you a little more, and then proceed with inquiry about specific symptoms related to GAD and Panic Disorder, as discussed in prior sections.

The GAD-7 (below) is a screening questionnaire that you can use as a starting point for inquiry, filling it out while in dialogue with patients, or having them complete it in the waiting area. It includes the 7 cardinal symptoms of GAD. The GAD-7 has been extensively validated for use in medical and surgical office practice. It was designed primarily as a screening and severity measure for generalized anxiety disorder, but the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. GAD-7 total score for the seven items ranges from 0 to 21, and a score of 10 or greater is the recommended cutpoint for further evaluation. (10).

There are seven cardinal symptoms of GAD, here shown in the GAD-7 format:

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>not at all</th>
<th>several days</th>
<th>more than half the days</th>
<th>nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Trouble relaxing 0 1 2 3

Being so restless that it is hard to sit still 0 1 2 3

Becoming easily annoyed or irritable 0 1 2 3

Feeling afraid as if something awful might happen 0 1 2 3

At a cutpoint of 10, the following sensitivity and specificities have been reported for four common types of anxiety:

<table>
<thead>
<tr>
<th>GAD = 10 or greater</th>
<th>GAD</th>
<th>Social Anxiety Disorder</th>
<th>Panic Disorder</th>
<th>PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>.89</td>
<td>.74</td>
<td>.72</td>
<td>.66</td>
</tr>
<tr>
<td>Specificity</td>
<td>.82</td>
<td>.81</td>
<td>.80</td>
<td>.81</td>
</tr>
</tbody>
</table>

This means that when using the GAD-7 for screening, 89% of patients with GAD will score 10 or more (true positives), and 82% of patients without GAD will score less than 10 (true negatives). 11% with a score of 10 will NOT have GAD (false positives) and 18% with a score less than 10 WILL have GAD, the false negatives.)

In addition, because almost half of patients with an anxiety disorder also have a depressive disorder, it is useful to screen the patient for depression as well. This can be done by asking

"Have you been feeling sad, blue, down in the dumps?"
"Have you noticed that you don't enjoy things as much as you used to?"

If the patient responds positively to either one of the two above questions, you should proceed further with an open-ended question, such as:

"Could you tell me a little more about your feelings of sadness or your loss of enjoyment?"

If depression is suspected, initiate a more thorough assessment for depression, as outlined in Module 27, or use a validated screening questionnaire such as the PHQ-9.

**Differentiate anxiety disorders from medical conditions and drug effects**

Many treatable medical conditions and a long list of medications cause anxiety. Be mindful of this critical issue in order to help patients avoid unnecessary suffering.

Many treatable medical disorders produce obvious and sometimes dramatic anxiety symptoms and findings. Too often, clinicians make a psychiatric diagnosis without conducting further inquiry, physical exam and diagnostic studies. Then the medical disorder such as hyperthyroidism or a central nervous system illness goes untreated, sometimes with tragic results.
When seeing patients with anxiety, be mindful of the likelihood that anxiety symptoms may be due to an underlying disease process. Ask questions and do the requisite physical exams that will help save patients from avoidable suffering. A partial list of common problems mistaken for anxiety disorders follows:

- Thyroid disease, particularly hyperthyroidism
- Pulmonary disease
- Parkinson’s disease
- Post-stroke anxiety
- Seizures
- Cognitive dysfunction (delirium, dementias)
- Alcoholism or drug addiction; either with withdrawal syndromes or without them
- Rare conditions, such as carcinoid or pheochromocytoma.

A very long list of medications produce anxiety as a side-effect, and two classes, the antidepressants and anxiolytics, are of special and paradoxical importance.

Some antidepressant drugs approved by the FDA for the treatment of anxiety disorders (e.g., certain SSRIs), can paradoxically cause anxiety. Occasionally, this substance-induced anxiety subsides as the person becomes adjusted to the medication. However, substance-induced anxiety can become intolerable and this possibility must be considered during assessment as well as during treatment.

Other anxiolytic drugs that can paradoxically cause anxiety symptoms are benzodiazepines (BZDPs), a class of drugs that is effective for both controlling anxiety and inducing sleep, yet can also cause symptoms indistinguishable from anxiety under special circumstances. When patients have been using BZDPs on a daily basis for long periods of time or at high doses, a “discontinuation syndrome” may occur if they stop the medication suddenly. This rapid cessation of a drug with sedative properties can lead to nervousness, agitation, sweating, sleeplessness, and other signs of CNS over-activation. In this case, urgent treatment is required, often including continuous medical supervision.

A list of other common drug classes that cause anxiety follows:
- Androgens
- ACE-inhibitors
- Antiarrhythmics
- Anticholinergics
- Antidepressants
- Antiemetics
- Antiinflammatory agents
- Antimycobacterial agents
- Antineoplastic agents
- Antipsychotics
- Antiviral agents
- Beta-adrenergic agonists
- Cannabinoids
- Corticosteroids
- Dopaminergic agonists
- GRH-active agents
- Histamine H2 receptor antagonists
- Interferons
- Methylxanthines
- Sympathomimetics
- NSAIDs
- Opiates
- Opioid antagonists
- Progestins
- Prokinetic Agents
Stigma hinders both symptom discussion and engagement with treatment

Minimize embarrassment and other obstacles to diagnosis and treatment with trust-building statements and common-sense explanations.

Anxiety is included in the general social stigma about mental illness or emotional problems. Consequently, patients may be embarrassed to disclose anxiety or symptoms of panic or may simply deny their presence.

The social stigma extends to patients without full-blown anxiety disorders, who may respond to simple inquiry such as, “Are you anxious?” with irritation, perhaps responding, “Of course I’m worried, who wouldn’t be worried, with all these physical problems and all the stress I am under.” This minimization of symptoms and resistance to talking about them frustrates clinicians. As noted in Modules 6 and 13, arguing with patients or falling back on authority, saying something like “Well, I do think you’re anxious even if you are not aware of it” hinders further dialogue.

Legitimation (normalization, validation), support and simple explanations presented straightforwardly without jargon and without conveying an implication of authority or superiority help resistant patients remain engaged. An example statement might sound like this (with suitable pauses for patient response—see Module 10):

“Many people in your shoes feel exactly like you feel. The kind of problems and stresses you have been having would certainly be upsetting for almost everyone. ... Over the years I have learned that when people struggle with these serious problems for a long time, their body begins to run out of the chemicals that help all of us cope with stress. ... Loss of those chemical helpers can lead to an imbalance which makes it even harder to cope and function effectively. Everyone under enough stress for long enough will have difficulty functioning at the level they usually can manage easily. ... In these high-stress situations, certain medications and self-management tools can really help. ... What do you think?”

Unless the clinician employs trust-building empathic statements and simple explanations of the “medical model” of the illness process, patients may become confused, frustrated and completely deaf to any treatment suggestions. Finding a response that not only reassures patients and suggests that you understand their perspective, but also encourages an alternative view of the situation enables continuation of the conversation.

Patients may use alcohol to self-medicate, but this culturally sanctioned practice is ultimately self-defeating because alcohol quickly loses any effectiveness, and heavy use may result in the development of alcoholism.

MANAGEMENT

Follow the sequence below to provide good treatment for patients with anxiety.

TELL THE PATIENT YOUR DIAGNOSIS
- Share your thoughts about how the illness process works (your “explanatory model,” module 9)
- Address stigma and barrier health beliefs
- Inform the patient about treatment options and offer choices when that is appropriate
- Agree with the patient on a specific treatment plan (Module 11) and document the discussion and the patient’s agreement (Module 17)
- Support the patient’s self-management strategies.

ONCE THE PATIENT BEGINS TREATMENT, THE SUBSEQUENT TASKS ARE THOSE OF ASSURING ADHERENCE AND MAKING ADJUSTMENTS DURING FOLLOW UP VISITS – (Module 16):

- Monitor symptoms
- Monitor adherence and address barriers
- Continue education about anxiety and about working together
- Elicit and address adverse events or concerns as they arise
- Reassess progress, adjust the treatment plan and agree on any changes to it
- Document the informed consent conversations so as to reflect changes in the plan

---

**Tell the diagnosis**

Patients often have difficulty understanding mind-body relationships and even more difficulty accepting that the symptoms relate to a treatable anxiety disorder

Many patients with anxiety come to the office complaining of symptoms like dizziness, headaches, muscle tension, and insomnia. They seldom relate these somatic symptoms to anxiety, so they are understandably disturbed when the doctor seems to “explain away” their symptoms by suggesting that anxiety causes them.

In fact, clinicians can easily be caught in that trap of seeming to discount physical symptoms in their effort to inform and treat patients’ anxiety. A multidimensional approach assists in maintenance of a partnership with patients. On the one hand, treat the physical symptoms with respect, evaluate somatic concerns and treat them conservatively. Meanwhile, treat anxiety as an independent cause of suffering and disability. For example, a conversation with patients with irritable bowel syndrome and a clinically significant anxiety disorder might sound like the following example, which illustrates a multidimensional approach:

"I hear very clearly that your stomach pain and bloating is a big problem for you. I am going to prescribe a new medication that should reduce your bloating and cramping, while we conduct a few simple tests. I also think that stress and anxiety are worsening your symptoms, and that treatment for the stress and anxiety will help us get your symptoms under much better control. If you are willing I’d like to talk about how we can treat the stress and anxiety, too."

As you increase your understanding of mind-body relationships, strive to develop communication skills that will enable you to effectively inform patients about the basis for symptoms using an explanatory model that integrates mind-body mechanisms. (module 9 &10)
Address “barrier” health beliefs and denial

Stigma about emotional problems is widespread and is both a cause and a result of health beliefs that act as barriers to good information and treatment. Ask about beliefs.

The most important barrier health belief is the notion that mental disorders signify personal weakness. This belief and barrier hinders development of a partnership and alliance between doctor and patient.

Establishing the presence of a barrier health belief is neither difficult nor complex, but the clinician has to take the initiative to ASK about it. The doctor might say something like the following:

“I think stress and anxiety is contributing to your symptoms. ... What do you know about anxiety?... What does the term mean to you?... How do you feel about the diagnosis of an anxiety disorder?”...

The patient’s response(s) may uncover health beliefs that can profoundly affect a working alliance, but also provide an opportunity to respond directly to barrier beliefs and concerns. An alliance-building response might sound something like the following:

“I understand how you might feel this way. Anyone exposed to enough stress will develop an anxiety disorder and it has very little to do with a person’s strengths or weaknesses. You may have heard that fully a third of the soldiers returning from Iraq have serious emotional problems from the extreme stress they were exposed to. Even astronauts, who are carefully selected for both physical conditioning and stress-resistance, have occasionally experienced symptoms of anxiety and depression during long-duration space missions.”

Patients who state, “I am not anxious,” or in other direct or indirect ways show that they do not accept your explanations or management strategies present a special dilemma. Denial of anxiety or resistance to explanations and treatment is especially troublesome when a patient has self-medicated with alcohol or other substances. Either because of fear, stigma or substance abuse, these patients are out of touch with their emotions, do not understand the mind-body connection and often reject recommendations for behavioral treatments in a dismissive fashion.

Sometimes the substance abuse issue must be addressed first (module 29 & 30). In some cases I have helped patients diminish their suffering by saying,

“It seems that standard medical care has been a serious disappointment for you. ... Relief may be in sight, however, as I know many patients with symptoms like yours who enjoyed considerable relief of their symptoms and their distress after they participated in a mind-body education program that teaches stress management.”

By removing the recommendation from the domain of mental health and reframing it in terms of health education, stigma may be avoided and adherence achieved.

Provide biomedical information, along with support

As you tell the patient your idea about the diagnosis, you have the opportunity to explain the concepts of anxiety and panic.

Education begins with an assessment of current knowledge:

“What is your understanding of anxiety?”
After responding to any verbal or non-verbal expression of concern with empathic statements, you can make concrete and clear statements about how modern medicine understands the condition. Explanations might include statements like the following (or parts of them), interspersed with opportunities for the patient to respond, and accompanied by relationship-building statements from you.

"While everyone has occasional worries or fears, an anxiety disorder is a different story. For a variety of reasons, such as genetic inheritance, age, and stress, the body and the brain are make too many stress hormones. Those chemical hormones provoke the symptoms you describe. In some cases, they can lead to a terrible cycle of panic attacks. Unfortunately, the worry caused by the symptoms make the problem even worse. Because people cannot predict when those hormones and chemicals will be most active, they get worried that they will get worse, or that something else will happen. Then that worry makes more hormones and the concern comes true and people feel worse, and so on. ...

"The panic attack cycle set off by the chemicals produce extreme symptoms, and help us understand. When someone has a panic attack, the chemicals make her heart pound and she may feel sweaty, weak, faint, or dizzy. Her hands may tingle or feel numb, and she might feel flushed or chilled. She may have nausea, chest pain or smothering sensations, a sense of unreality, or fear of impending doom or loss of control. She may genuinely believe she is having a heart attack or losing her mind, or on the verge of death. The feelings of terror strike suddenly and repeatedly, with no warning, and for no good reason. Because she cannot predict when a terror feeling will strike, she becomes very anxious between episodes, worrying when and where the next one will happen, and then that worry makes more hormones and another attack gets set off. ...

"The good news, however, is that panic disorder and other anxiety problems caused by these chemical hormones are easily treated and can usually be controlled. It’s a physical condition and nothing to be embarrassed over. Would you like to learn about the various treatment options?"

Personalized, interactive, online programs for the technology-supported management of anxiety are available; expect more such programs to be available for wireless devices.

---

**Negotiation of a treatment plan**

Many patients will accept treatment recommendations. Because of stigma or disbelief that mind and body are so intertwined, or both, others are reluctant to accept. Adopt an empathic and unpressured approach that communicates your interest in continuing partnership.

The strategies of skillful exploration of patient perspectives (M 9), thoughtful information-sharing (M10) and reaching agreement (M11) strengthen the alliance with patients and provide them with the best possible outcome at any given visit. A conversation with a reluctant patient might proceed as described in the following paragraphs.

"You have an anxiety disorder that usually improves with treatment. Anxiety improves with proper medication. And anxiety also improves with counseling or psychotherapy. Some people prefer both medication and counseling, which is often the most effective path to follow. Some self-management approaches are effective for mild anxiety. Would you be interested in these treatments? Of course, I'll tell you my recommendations."
Patients who are reluctant or refuse treatment at the time of first diagnosis may be open to some conservative self-management approaches such as exercise, meditation, and stress management. Many agree to more intensive treatment later. Always remain supportive of the patient, even when you believe they are making a poor choice, and leave the door open to future treatment. Inviting significant others into the discussion can also be helpful. You might say something like the following:

"I understand that you are not interested to start treatment now. I hope you might think more about what I have said, perhaps talk to your husband (or wife, or parents, etc) and even bring him (or her or them) to your next appointment. I’d like to continue to work together, and see how you feel in say, two or three weeks? ... You might also want to try some self-help approaches during this time to see if they can make a difference. Would you like me to provide some educational materials or direct you to online information that many patients have found to be useful?"

Personalized, interactive, online programs for the technology-supported management of anxiety are available; expect more such programs to be available for wireless devices.

If the patient clearly is not ready to accept treatment, the tenor of the statements above amounts to "watchful waiting.” You clearly state that you will not "abandon” the patient, and that you are prepared to continue the conversation at a later date.

---

**Self-management support (SMS)**

You can help your patient with chronic anxiety problems by helping the patient design and stick to a self-management plan. The "5 A's" provide a useful organizing framework for assisting the patient.

Anxiety is a chronic, recurring illness. Sometimes it is a life-long problem. Like patients with other chronic illnesses such as diabetes and heart failure, patients with anxiety who come to accept responsibility for self-management have better quality of life and the best long-term outcomes. You can help your patient with chronic anxiety by supporting the patient’s self-management. One model for guiding self-management is known as “the 5 A’s of Self-Management Support”, based upon the work of Lorig, and others. The 5 A’s are discussed in M 16 and M 24. Here we offer examples of how the 5As could be used for patients with anxiety disorders.

**Assess**

On follow-up visits, patients with ongoing anxiety symptoms may not have addressed contributory factors that can precipitate or aggravate anxiety, or new issues may have arisen, so ask about the following issues, or revisit them if you asked previously.

- *Life stressors* (recent losses, job changes, finances)
- *Diet* (caffeine in colas, coffee, tea; stimulants in chocolate)
- *Medications* (asthma and cold medications, steroids, etc. See list in Diagnosis section)
- *Alcohol use or use of other substances*

Ask patients what efforts to control anxiety they have already made? Inquiry should include the following areas:

- *Exercise*, including Yoga, Meditation or Relaxation training, etc
- *Self-help* manuals and stress management tools
- *Psychotherapy*

Ask what has previously helped, and are they willing to return to doing what helped in the past?
Would they like a recommendation about a new strategy? Can they do this on their own or do they need a coach to guide their self-management program?
Ask about how convinced they are that they should take some action, and how confident they are about their ability to follow any proposed course of action.

Ask directly but not in an accusatory way about medication adherence, perhaps with a question like the one that follows:

"Many patients find it difficult to take their medication as prescribed for a variety of different reasons. Has this been true for you?"

If the patient acknowledges problems, continue the exploration.

"Sometimes people stop taking their medication because of unpleasant side effects. Have you experienced side effects that led you to discontinue your medication?"

**Advise** refers to information about anxiety or its management. You might say,

"Many patients tell me how hard it is to take the medication every day, and I understand this problem. Anxiety medications have some special problems—sometimes I the medication takes a few weeks to kick in, and if you don’t take it regularly, you don’t get the benefits. May I share with you some of the suggestions that many of my patients find helpful?" Or...

"Patients with anxiety usually tolerate caffeine poorly. It makes anxiety worse and should be eliminated from your diet. That can be hard to do, so I suggest that you slowly eliminate it by mixing decaffeinated coffee with your regular coffee and gradually reduce your caffeine intake over a period of several weeks."

**Agree** involves helping the patient develop and set a specific personal action plan. Personal action plans should be specific **behaviors**; e.g., taking medication twice daily, exercise three days a week, meditate for 20’ daily, etc. The strategies in a personal action plan must be developed and agreed to by the patient, although the clinician usually provides helpful suggestions. Here is an example of patient-centered personal action planning,

"Since it is hard to take medication regularly, I wonder if you wish to make any plans now about how to take your medication?"

**Assist** refers to helping patients’ develop solutions to barriers to carrying out personal action plans, such as cost, discomfort, medication side-effects, or difficulty sticking to a planned routine.

"It sounds like you are having trouble getting started on your meditation practice. Let’s brainstorm about changes you could make that might get you going; what ideas do you have?"

**Arrange** refers to ensuring that follow-up arrangements are tailored to the patient’s specific needs.

"I want to track with you how you are feeling and how you’ve been able to do with your action plan. Two weeks seems right to me... What do you think?"

VIDEO (not shown in print-out text)
Steven Locke, MD, is the Clinician in this video
CONCLUSION

The skills elaborated and described in this module can be used to communicate effectively with anxious patients, to evaluate whether their anxiety symptoms stem from an anxiety disorder, to inform patients about the meaning of their symptoms, to minimize patients’ pain and suffering, and to initiate treatment.

Anxiety disorders are disruptive, painful, and serious medical conditions that contribute to poor relationships, social isolation and poor work performance, and frequently lead to development of a substance abuse disorder.

Anxiety disorders are treatable. Good communication skills enable clinicians to build a strong alliance with patients. When patients experience a trusting and respectful relationship, they disclose symptoms, listen to clinicians’ descriptions of how and why anxiety disorders make them feel poorly, and are more likely to undertake treatment and adhere to recommendations. In addition, clinicians who utilize these strategies make positive contributions to their patients’ lives and enjoy the professional gratification that comes from helping to relieve suffering.

RELEVANT BEHAVIORS

1. **Build a Relationship**
   - Accept, legitimate, and name patients’ emotions; and show congruent nonverbal behavior.
   (See Module 6 and 14)

2. **Open the Discussion**
   - Negotiate agenda for session

3. **Gather Information**
   - Explore somatic symptoms first, and then explore any emotions that patients mention
   - Reflect back to patients your observations of behaviors that suggest anxiety
   - Ask about concerns, nervousness and triggers for emotions, particularly anxiety
   - Explore impact on patient’s life and family
   - Ask about dietary intake of anxiogenic substances; depression, substance use, medical conditions; job, school, family, friends
   - Ask about family history

4. **Understand Patients’ Perspective**
   - Elicit patients’ explanatory model, and ask about efforts to control symptoms
   - Ask what patients know about mind-body interaction
   - Ask about patients’ goals and expectations for treatment

5. **Share Information**
   - Tell about mind-body interaction
   - Discuss the “it’s all in your head” notion
   - Present treatment options
     - Self-management
     - Pharmacotherapy
     - Psychotherapies
6. **Reach Agreement**
   - Explore patient’s motivation to change and confidence in ability to do so
   - Negotiate an action plan
   - Explore barriers to change or adherence
   - Brainstorm and problem-solve solutions

7. **Provide Closure to interview**
   - Summarize goals for next visit
   - Arrange resources, referrals, prescriptions, and schedule follow up.

---

**LITERATURE REFERENCES and ADDITIONAL RESOURCES**


---

**Additional Resources**

- National Institute of Mental Health (NIMH)
  Office of Communications and Public Liaison
  6001 Executive Blvd., Room 8184, MSC 9663
  Bethesda, MD 20892-9663
  Toll-free information services:

- Anxiety Disorders: 1-88-88-ANXIETY
  Depression: 1-800-421-4211
  General inquiries: (301) 443-4513 TTY: (301) 443-8431 E-mail: nimhinfo@nih.gov; Web site: www.nimh.nih.gov Anxiety Disorders Association of America
  8730 Georgia Ave, Suite 600
  Silver Spring, MD 20910
  (240) 485-1001
Freedom from Fear  
308 Seaview Avenue  
Staten Island, NY 10305  
(718) 351-1717  
www.freedomfromfear.com

Obsessive Compulsive (OC) Foundation  
337 Notch Hill Road  
North Branford, CT 06471  
(203) 315-2190  
www.ocfoundation.org

American Psychiatric Association  
1400 K Street, NW  
Washington, DC 20005  
(888) 357-7924  
www.psych.org

American Psychological Association  
750 1st Street, NE  
Washington, DC 20002-4242  
(202) 336-5510 / (800) 374-2721  
www.apa.org

Association for Advancement of Behavior Therapy  
305 7th Avenue, 16th floor  
New York, NY 10001-6008  
(212) 647-1890  
www.aabt.org

National Alliance for the Mentally Ill  
Colonial Place Three  
2107 Wilson Blvd., Suite 300  
Arlington, VA 22201  
1-800-950-NAMI (-6264) / (703) 524-7600  
www.nami.org

National Mental Health Association  
2001 N. Beauregard St, 12th floor  
Alexandria, VA 22311  
1-800-969-NMHA (-6642) / (703) 684-7722  
www.nmha.org

National Center for PTSD  
U.S. Department of Veterans Affairs  
116D VA Medical and Regional Office Center  
215 N. Main St.  
White River Junction, VT 05009  
(802) 296-6300  
E-mail: ncptsd@ncptsd.org; Web site: www.ncptsd.org

For Information About Clinical Trials  
NIMH Clinical Trials Web Page  
www.nimh.nih.gov/studies/index.cfm
Welcome to DocCom Module 27: Communicating with Depressed Patients

by Steven Cole, M.D.

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Facilitator Guide of this module for doc-com Residency Doctoring Curriculum

Credits:

Authors: Steven Cole, MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Casting of the Standardized Patients: Benita Brown
Questions for Reflection:

1. Considering your personal life and those of your friends and family, to what extent are you able to differentiate depressed feelings and affect from clinically significant depression?

2. Have you or anyone you have known been treated for depression? How have those experiences influenced your attitudes and skills related to working with depressed patients?

3. Has anyone you have known personally ever been suicidal? How has that experience influenced your attitudes and clinical care?

4. In what ways have you encountered stigma with respect to depression? In what ways could stigma affect the way you interact with and support your patients?

Key Principles:
1. Depressed affect is common, but clinically significant depression is a serious medical condition that requires focused communication skills to manage appropriately.

2. All patients with clinically significant depression must be assessed for suicidality.

3. Specific communication skills help clinicians to respond to depressed affect, to manage stigma, negative health beliefs and resistance, and to collaborate in negotiating effective treatment strategies.

---

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe the differences between depressed affect and clinically significant depression.
- Inquire about the nine symptoms of major depression.
- Ask five questions to evaluate suicidality.
- Demonstrate empathic interactions with depressed patients.

---

**INTRODUCTION**

Many mistaken beliefs limit diagnosis and treatment of major depression, a common illness. Specific communication skills help clinicians to overcome the typical barriers, and to facilitate their patients’ short-term and long-term management and healing of depressive illnesses.

The illness of depression and its variants are common in society, and more common in people who are seeking medical care, but the diagnosis is frequently overlooked. Social stigma and negative attitudes limit the insight, interest and ability of both patients and clinicians to discover depression. Patients with depression often complain of physical symptoms and clinicians frequently fail to connect these somatic problems with other clues to establish the correct diagnosis. Treatment of depression is effective, and many patients go unnecessarily untreated, continuing to suffer, miss work and cause distress in friends and families. This module presents basic concepts as well as special communication challenges, and focuses on strategies and skills that will assist patients to become more comfortable discussing symptoms and more likely to accept the diagnosis and treatment of depression.

---

**MULTIPLE MEANINGS OF "DEPRESSION"**

"Depression” can mean either the feeling of “sadness” or a serious illness. Misunderstanding and carelessness in using “depression” leads to misdiagnosis and substandard care.

The term “depression” has at least two related, but distinct meanings. On the one hand, the word "depression“ refers to an affect, a feeling state, which can be brief or long lasting. A synonym for depressed affect would be “sad.” Another use of the term, however, refers to a clinically significant medical illness that has specific signs, symptoms, and treatments. There are several different depressive syndromes – major depression, dysthymic disorder, and adjustment disorder with
depressed mood. Major depression is an illness and disease state, characterized by dysregulation of various neurotransmitters in selected areas of the brain, associated with genetic predispositions, a variety of personality variables, early life history, and current stressors.

In both the lay public and within the medical context, the word depression is used in both ways – a circumstance leading to confusion among both clinicians and patients. Skilled clinicians have a clear understanding of the different meanings of the term, “depression,” and are able to utilize communication skills for both contexts.

**MAJOR DEPRESSION**

The illness of depression has both psychological and physical symptoms.

Major depression is the core depressive syndrome. Two cardinal signs/symptoms--depressed affect and anhedonia (lack of the ability to experience pleasure)--characterize major depression, along with 7 other symptoms, 4 physical and 3 psychological. Four physical ones are sleep disturbance, appetite/weight disturbance, fatigue or loss of energy, and psychomotor agitation or retardation. Three psychological ones are poor concentration, low self-esteem or guilt, and thoughts of death or suicidal ideation. The two cardinal symptoms along with the two other groups of symptoms, (physical and psychological), are often considered the four hallmarks of major depression. In addition, irritability is not one of the “diagnostic” symptoms of depression, but irritability is common in major depression and dysthymia, and clinicians should ask about it. Patients with relatively persistent depressed mood or anhedonia for at least two weeks, along with a total of any 5 of the 9 symptoms listed above meet criteria for the diagnosis of major depression.

**Depression can be fatal**

Every person experiences grief and sadness, but the illness of depression (“clinical depression”), with its persistent symptoms, has high morbidity and mortality.

Clinicians and patients should not confuse the presence of depressed affect (sadness) with the clinical syndrome of major depression for several important reasons. First, depressed affect is a universal and unavoidable part of the human condition. However, regardless of circumstances, it is distinctly abnormal for all-encompassing, painful, and debilitating sad affect to persist day after day, week after week, and month after month. In major depression, such a persistent sad affect often accompanies anhedonia and the other physical and psychological symptoms described above. Secondly, major depression is a serious medical disorder with many negative health consequences, even death. Depression is associated with suicide, and depression predicts future coronary artery disease and cerebrovascular disease as well as increased morbidity and mortality of many other physical conditions. For example, the myocardial infarction patient who suffers from major depression after the heart attack is 2-3 times more likely to die in the next few years than patients without depression. About 20% of heart attack patients suffer from major depression.(1)

Finally, major depression is usually treatable and reversible.

**Distinguish depression from grief**

Grief can be devastating, but it is limited to the feeling of sadness and it is transient. People with depressive illness develop symptoms in addition to sadness, and the symptoms persist over time.
When people suffer a loss, a grief response is normal, and sadness is a major component of that grief. Note that grief can follow any kind of loss, not only the death of a loved one. People grieve after the break up of a love relationship. They grieve after losing a job, losing a limb, or loss of capacities from other illnesses, such as loss of ability to play tennis after a back injury. A person may grieve having to give up a stressful job or stressful lifestyle after a heart attack. People may even grieve after losing something they never had – as when one realizes he will never achieve a dearly held dream.

Grief often has a natural history, including periods of denial, anger, and sadness. Depending on personality, gender and the severity of the loss, most people are through the worst suffering in months and return to baseline in 6 -12 months, though some sadness and longing may last for years. Clinicians commonly think, “Of course she’s depressed, look at what she lost;” however, the sadness accompanying grief is normal, while the sadness of depression signals an illness. People who are grieving certainly feel sad, but do not experience all the other hallmarks of depression such as low self esteem, guilt, suicidal thoughts, loss of appetite, poor sleep, and fatigue. Sometimes grief triggers a depressive illness, and when it does, the illness needs treatment. (1,2)

---

**Respond to tears**

Witnessing the suffering indicated by tears stands as a fundamental component of the mission of medicine. Skilled and compassionate responses to crying facilitate efficient and effective medical care.

The sadness in patients’ lives as well as the sadness of chronic or serious illness is an inescapable part of medical practice. Patients commonly cry in the doctors’ office. Some clinicians think that patient tearfulness distracts from the “real” work of medicine, but nothing could be further from the truth. Clinicians who take their mission to relieve patient suffering seriously will strive to mindfully attend to the distress of the patient who is sad, and assist in relieving it as skillfully as possible.

In general, as a window into the patient’s soul, tearfulness becomes a unique opportunity to understand the patient and to build a strong alliance. In fact, it is often a good sign when a patient cries. First, it usually means you have gained the patient’s trust, as patients generally do not cry in the presence of a clinician he or she does not trust. Second, tears usually accompany the discussion of an important life issue which you must help the patient address. Third, the tears may be an important signal to the presence of a depressive illness. Tearfulness seldom interferes with the other work of a visit, and most patients will cry for less than a minute, often apologizing and saying that they did not want to cry in your office. As you come to understand the thoughts that provoke sadness and tears, you gain an invaluable insight into the patient. Your empathic response begins the process of improving your understanding, and builds a solid therapeutic and working alliance that improves health outcomes.

Once a patient begins to tear up, or starts to cry, a simple reflective or caring comment is facilitative, shows your concern and encourages the patient to say more:

“*I’m so sorry*” or, “*I can see this is very hard for you.*”

After a few brief sentences from the patient, you may already understand enough about the situation to make a meaningful legitimating (emphatic) statement, such as,

“*Anyone would be distressed in this type of situation. I am sure I would be quite upset if I were in this situation also.*“
NEGATIVE ATTITUDES

Negative attitudes about sadness and mental illness are common, and negative responses to them can seriously undermine the clinician-patient relationship. Ultimately, they impair clinicians’ clinical effectiveness.

Many patients and clinicians have had emotionally charged personal experiences with depression that shape their current attitudes. They may have had a depressed parent or relative whom they could never please or help; a depressed parent who was always angry, depriving or even abusive; or perhaps a depressed parent who helped cultivate a profound sense of responsibility for caretaking of others. Conversely, many clinicians have experienced depression themselves or have had a depressed spouse or child with depression. With the strong cultural emphasis on independence and achievement, depressed individuals may feel guilty or distressed because they lack energy to be self-sufficient and productive, thinking they should be able to “pull themselves up by their bootstraps.” These factors contribute to the widespread notion that mental illness, including depression, is a form of moral weakness or failure. Like their patients, clinicians may also hold these negative, stigmatizing attitudes toward depression. Unfortunately, medical trainees and practicing clinicians themselves suffer from high rates of incident and chronic depression.

Patients commonly explain away depressed feelings as “understandable” or “normal” under stressful circumstances. They deny to themselves and others that they may be suffering from clinically significant depression, often thinking or saying that they have “good reasons” to feel sad under the circumstances. If they are grieving a loss, they may mistake a new clinically significant depression for a normal grief reaction.

Consider your personal experiences with depression and reflect on how those experiences have shaped your attitudes. You might have difficulty connecting emotionally with patients who have a depressed affect, or you may worry about “making” patients cry. Many medical trainees are overly cautious about asking about emotional topics, or worry about “prying” into the causes of a patient’s sadness. Such concerns are common and normal, but can seriously impair your clinical effectiveness. Exploring your own attitudes and coming to terms with those which could hinder your effectiveness, will enable you to view depressive illnesses more positively and to care for depressed patients with skill and empathy.

ESTABLISH A DIAGNOSIS

Patients often conceal their sadness or do not complain of sadness. Few clinicians employ screening strategies routinely. The rapid pace of medical practice may impede diagnosis of depression.

Depression is common among medical patients. In disadvantaged populations the prevalence may exceed 30%, which argues for vigilance and frequent screening. Some clinicians and researchers argue that every patient should be assessed for depression at every visit, but we believe targeting screening assessments to patients at high risk for depression represents a more efficient and pragmatic strategy. High risk patients have been shown by research to include those with chronic illnesses (diabetes, heart failure, etc), patients with recurrent unexplained physical symptoms such as pain, fatigue, neurological symptoms, etc, and patients undergoing life transitions or unusual stress.

Too few general clinicians discover their patients’ depressive illnesses. Studies show that in primary care practice, about half of patients with depression do not receive a proper diagnosis. Many factors contribute to this problem. Patients with depression often appear to have normal affect often make a very conscious effort to hide their sad feelings. Patients seldom complain
directly of depression. Clinicians can uncover hidden depression with screening strategies, but few clinicians routinely screen patients for depression. Medical practice today suffers from compelling time constraints, and clinicians may focus their attention on other acute and chronic medical problems that demand immediate attention.

**Ask about sadness and other symptoms**

Ask direct questions about sadness, and follow up with further open-ended inquiry.

Eliciting the symptoms of depressive illness can be very straightforward. However, clinicians should practice with mindfulness of the high prevalence of depressive disorders and attention to overcoming their own internal reluctance or hesitation about working with patients’ sad affect. Finally, clinicians must remember to ask directly about depressed affect, anhedonia and other symptoms.

Effective opening questions are simple. For example:

"*Have you been feeling sad, blue, down in the dumps?*"

"*Have you noticed that you don’t enjoy things as much as you used to?*"

If the patient responds positively to either one, proceed with further open-ended interventions, saying something like:

"*Could you tell me a little more about your feelings of sadness or your loss of enjoyment?*"

Remember to respond actively and compassionately to patients’ verbal and non-verbal expression of emotions.

**Attend to non-verbal signals**

Non-verbal signs can alert clinicians to possible depressive illness and avoid ineffectual pursuit of somatic symptoms.

Many patients with depression who conceal their sadness emphasize somatic symptoms such as insomnia and poor appetite or lack of energy. This distracts clinicians, who may focus on the characteristics of symptoms and order endocrine, cardiac or other work-ups that are expensive, time consuming and ultimately fruitless.

However, patients often display non-verbal and para-verbal hints of underlying depression, and alert clinicians notice these signals, comment on them and follow up.(m14) Patients may look down when speaking, sigh frequently, or take in a breath as though they were going to sigh and then speak instead, with a breathy quality to their voices. They may reach for their eyes or dab at them, though there are no tears, or their eyes may start to glisten, as though they might cry. They might make helplessness gestures (a shrug of the shoulders, an upturned hand gesture followed by the hand dropping to the lap or table). Their voices may trail off by the end of a sentence, or have a “flat” quality. Some will show an anxious affect or other signs of anxiety, which often accompanies depressive illness. Another hint is your own affect. If you suddenly feel sad about or sorry for the patient, it is often related to the patient’s sad affect. If you notice any of these, and simply say to the patient, “you seem sad to me,” followed by silence, the patient will often start to cry.
Stigma produces conflict

Because of the stigma attached to depression, patients and clinicians too easily attribute symptoms to “stress.” Responding supportively is possible.

Substantial social stigma concerning all mental illness (including depression) exists in the public today, and as a result, many patients are embarrassed to disclose depressed affect or may simply deny its presence. This can create a head-to-head conflict between doctor and patient. For example, the patient with chronic illness, physical complications, and significant life stress may have trouble sleeping, have trouble with energy and trouble with fatigue. When asked, "Are you depressed?" the patient may respond by saying something like, "Of course I’m depressed doctor, who wouldn’t be depressed, with all these physical problems and all the stress I am under!"

How can you respond to this challenge? It is helpful to reassure the patient and support his or her defense, while also encouraging a different perspective. Responses like the following are often helpful:

"Many people would feel exactly like you feel. The kind of problems and stresses you have been having would certainly be upsetting for almost everyone. But I also wonder whether you might be suffering from a kind of chemical imbalance that is now making it even harder for you to feel OK and harder for you to function. If so, treatment can really help."

Busy, rushed clinicians occasionally invoke their medical “authority” when challenged by patients who deny depression. When challenged in this way by patients who are responding to the stigma, clinicians not uncommonly turn to defensive, distancing, un-facilitative and counter-productive responses, and say something like, "Well, I do think you’re depressed even if you are not aware of it.” Do not say anything like this! Try a simple empathic statement such as, "Seems we are not quite on the same page; ...I hope I can find a way to be helpful to you."

Getting around denial

Asking about symptoms other than depression or sadness is a reasonable way to engage patients and avoid potentially troublesome denial and unnecessary conflict.

Denial of depression is a troubling patient response, and a frank denial discourages compassionate responses from clinicians and invites difficulty in the doctor-patient relationship. When asked a question about depression, the patient may simply state, "I am not depressed." How can you respond to that, if other symptoms seem to point to depression?

When the skilled clinician realizes that the patient may deny depressed affect or clinical depression, he or she will strategically avoid or postpone direct questions about depressed affect, especially in the earlier phases of the interview. Inquiry about anhedonia is less threatening than talk about depressed affect. Instead of addressing depressed affect, it may be more judicious to begin with a question about anhedonia, such as,

"I have been wondering if you’ve been enjoying life lately?" or  
"I wonder what you’ve been doing for fun these days."

If the patient acknowledges anhedonia and at least four of the other nine symptoms of depression, the patient meets criteria for major depression even without acknowledging or counting depressed affect as one of the nine symptoms of clinical depression. For the purposes of diagnosis, then, the patient’s response to inquiry concerning depressed affect is actually not pivotal to the diagnosis of
ASSESS SUICIDE POTENTIAL

Ask each patient with depression about suicide, and be certain to know the 5 key questions that help assess suicidality.

Every patient with depression should be considered a potential suicide risk and needs evaluation. Suicide assessment usually begins with a broad question about hopelessness, such as,

“Do you sometimes feel that life is not worth living anymore?”

The patient who answers positively to this question is said to have “passive” suicide ideation. Continue the interview to determine whether or not the patient also has active suicidal ideation. If the patient responds positively, follow-up with an open-ended question like, “Can you say some more about this?”

Five follow-up questions comprise the basic and essential suicide evaluation in the primary care sector. If the patient does not reveal answers in response to an open-ended question (above), these five questions should be asked directly:

1. “Do you ever think about actually killing yourself?”
   (If the answer is “Yes,” ask, “Can you tell me some more about those thoughts?”)

2. “Have you ever made an attempt on your life?”
   (If the answer is “Yes,” ask, “Can you tell me some more about that?”)

3. “Do you have a plan?”
   (If the answer is “Yes,” ask, “Can you tell me some more about your plan?”)

4. “Having a thought is different from actually carrying out a plan. Do you think there is a chance you might act on this plan before I see you again?”
   (If the answer is “Yes,” ask, “Can you tell me some more about that?”)

5. “If you do begin to lose control of yourself, do you think you could call me or go to an emergency room before you act on any impulse to hurt yourself?”

The patient who claims he or she will contact the clinician or an emergency room is said to be able to “contract for safety.” Contracting for safety is a useful intervention, but little research evidence supports its use. Thus, the ability or willingness to contract for safety may be a modest clinical measure of suicide risk, but you cannot use this guideline mindlessly.

Patients who answer “yes” to questions 1 or 2 should be considered moderate suicide risks, while any patient who responds positively to questions 3, 4 or 5 should be viewed as a high suicide risk, and requires immediate action, for example referral to a psychiatrist.

PRESENTING THE DIAGNOSIS

After establishing the presence of clinical depression and evaluating for suicide, share your thoughts with the patient, and address stigma and barrier health beliefs. Tell patients they have depression, but do not discount the primacy of their somatic symptoms and the effects of...
denial and stigma.

Telling patients you think they have clinical depression can be a challenge. Many patients with depression come to the primary care doctor’s office with chief complaints relating to physical symptoms like pain, fatigue and insomnia. They do not experience their problems as depressive in origin, so they are understandably concerned if doctors attempt to “explain away” their symptoms as caused by a depression.

Do not get caught in the trap of discounting physical symptoms in the effort to properly diagnose and treat depression. Maintain a two-armed or multidimensional approach: treat the physical symptoms with respect and concern, evaluate them and treat them conservatively and responsively. However, also treat the depressive syndrome as an independent cause of suffering and disability. For example, the patient with stomach discomfort and a clinically significant depressive syndrome should be managed with the two-armed multidimensional approach, such as:

“I understand the stomach pain is a problem. We want to do a few more tests and I am prescribing a medication that should lower your production of acid. And I would also like you to consider treatment for another condition I think you are suffering from: clinical depression...”

Address barrier health beliefs

Ask what the patient knows or feels about depression, and counter the belief that depression is a "weakness" by separating characteristics like “strength” from illness.

Stigma about mental illness and depression serves as both the cause and result of “barrier” health beliefs. The most important barrier health belief is the notion that depression is a sign of weakness. This belief imposes a barrier that discourages a treatment alliance between doctor and patient. Clinicians can recognize the presence of a barrier health belief and address it straightforwardly.

The only sure way to recognize the presence of a barrier health belief is to ask,

“I think you have some clinical depression...What do you know about depression? How do you feel about the diagnosis of depression?”

The patient’s answers will uncover health beliefs that can profoundly affect a working alliance with the patient. If the patient says something like, “Only weak people get depressed,” you now have some insight into factors that may lead to non-adherence and have an opportunity to respond directly to the patient’s concerns.

The clinician can then say something like,

“I understand how you might feel this way, and many people have the same feelings. It is important for you to know that anyone can get caught up in depression and it has nothing to do with a person’s strengths or weaknesses.”

Share information about depression

Considerable research points to structured strategic steps that ultimately help patients understand the illness, construct a manageable treatment plan, and adhere to it. The first step requires elicitation of the patient’s beliefs and perspectives, followed by the provision of small
amounts of information directed at those beliefs, followed by a check for understanding.

Effective education about depression begins at the same time that the clinician first presents the diagnosis to the patient. Good care necessitates understanding the patient’s knowledge and perspective, with a question like, "What is your understanding of depression?"

After the patient answers this question, you can respond to the patient’s emotional and cognitive concerns, and then offer short, concrete, clear statements explaining the condition. Sometimes clinicians try to “educate” their patients with long monologues that are poorly understood and poorly attended to. Patients become confused and overwhelmed with long explanations. On the other hand, clinicians who pause after providing short educational messages find that patients often understand better and reply with statements and questions that facilitate emotionally relevant as well as efficient and effective information transfer.(m9,10)

"While everyone gets sad once in a while and particularly when bad things happen, clinical depression is a different story. Clinical depression has a persistent sadness and loss of enjoyment that is related to chemical imbalances in the brain that also cause poor sleep, low energy, slow movements, change in appetite, poor concentration, low self-esteem or guilt, and hopelessness...

The good news is that the condition is treatable...

We usually prescribe either antidepressants and/or counseling...

I think you owe it to yourself to consider one or both of these treatments. You deserve to feel better.

What do you think...are you willing to consider treatment for your depression?”

Some clinicians compare depression to other chronic illnesses with chemical deficiencies, such as hypothyroidism or diabetes.

“Depression is a deficiency syndrome like diabetes. If you don’t have enough insulin coming from your pancreas, your sugar goes up. In depression there is a deficiency of serotonin, a chemical in your brain that you need to have a normal mood. If you don’t have enough serotonin being produced in certain parts of your brain, it affects how you think and feel; you will have a low mood.”

---

**NEGOTIATE TREATMENT PLANS**

Getting treatment at some time is more important than insisting that treatment begin today. Offer choices, including “non-medical” ones like exercise and socializing. Support autonomy and involvement, and assist the patient in developing a long-term plan for self-management.

Because many patients will resist accepting the diagnosis of depression or resist starting treatment, either counseling or medication, an open-minded attitude of flexible negotiation to the encounter is helpful. Offering choices supports patients’ sense of autonomy and involvement with planning, and increases adherence to the treatment selected.

“You have a clinical depression that usually responds very well to treatment. There are different treatments available. Depression responds to treatment with medication. And depression also responds to treatment with counseling. Some people prefer treatment with both medication and counseling, which is often the most powerful treatment. My personal recommendation for you now is that you consider treatment with both medication and counseling. Would you be interested in these treatments?”
Patients who refuse treatment initially may agree to treatment at a later point in time. Always leave the door open to future treatment. Inviting significant others into the discussion can also be helpful. You could say something like,

"I understand that you are not willing to start treatment now. I would like you to think some more about what I have said, perhaps talk to your husband (or wife, or parents, etc) and even bring him (or her or them) to your next appointment. We will watch you closely and see how you feel at your next appointment in say, two or three weeks."

Other strategies can help. Prescribing daily aerobic exercise helps alleviate the symptoms of depression. Encouraging patients to renew ties to friends, community, and places of worship can help relieve the isolation of depression and enhance social support.

"You haven’t been going to church since your symptoms began a few months ago - I remember you used to be a regular church-goer and enjoyed volunteering at church suppers and the like. It will really help you feel better if you try to get back to the things you used to enjoy. I think it would be a good idea for you to consider starting to go to church again. Perhaps you would consider going this Sunday? What do you think of that idea?

Support self-management

Patients benefit from clinicians’ strategic facilitation of their personal short-term and long-term plans to manage the behaviors that influence their health.

Depression is a chronic, recurring illness. Like patients with other chronic illnesses, such as diabetes and heart failure, patients with depression who can learn about the illness and accept the responsibility for self-management have the best quality of life and the best long-term outcomes. You can help your patient with chronic illness by supporting their own goal-setting and problem-solving.

Evidence-based techniques that clinicians can use to support self-management are contained in the framework of the “5A’s: assess, advise, agree, assist, and arrange.” (m16, 24, 25) Another useful framework for encouraging self-management is UB-PAP.

Ultra-Brief Personal Action Planning : (UB-PAP) ©

The Ultra-Brief Personal Action Plan has 5 core elements:

1. The plan must be truly patient-centered, that is what the patient himself/herself actually wants to do, not what the doctor told him/her to do.
2. The plan must be behaviorally specific – that is very concrete and specific about what, when, where, how long, etc.
3. The patient should re-state the complete plan (i.e. “commitment statement”). The plan should be associated with a level of confidence (on a 1 to 10 scale) of 7 or greater.
4. If the confidence level is <7, the clinician and patient should begin problem-solving on strategies to modify the plan.
5. There should be a specific date and mechanism for follow-up (or accountability).

The Ultra-Brief Personal Action Planning is structured around 3 core questions:

1. Elicit patient preferences/interests for behavior change

   "Is there anything you would like to do that will help you feel better over the next few days (weeks) before I see you again?"
Elicit commitment statement (e.g. “I will walk for 20 minutes, in my neighborhood, every Monday, Wednesday and Friday before dinner”)

2. Check confidence level

“That sounds like a great plan. But changing behavior and sticking with a plan is actually very hard for most of us. If you consider a confidence scale of 1 to 10, where ‘10’ means you are very confident you will carry out the plan and ‘1’ means you are not at all confident, about how confident are you?”

If confidence level <7, problem solve solution

“That’s great that you feel a confidence level of 5. That’s a lot higher than 1. I wonder if there are some ways we could modify the plan so you might get to a confidence level of 7 or more. Perhaps you could choose a less ambitious goal, ask for help from a friend or family member, or think of something else that might help you feel more confident about carrying out the plan”?

3. Arrange follow-up

“Great, so let’s make a date for our next appointment, so we can check on how you’re doing with your plan.”

CONCLUSION

Because depression is such a painful, serious, but treatable condition, clinicians who develop the communication skills to meet these challenges will make positive contributions to their patients’ lives.

This module reviewed the special challenges of communicating with depressed patients. Clinicians need special skills to meet the many challenges of depression assessment and depression management in the general medical setting. In addition, clinicians who treat depression successfully will also feel the professional gratification that comes from helping patients feel better, from enhancing their quality of life and from improving their general medical prognosis.

BEHAVIOR CHECKLIST

- Respond to depressed affect with empathy.
- Adopt attentive nonverbal position, such as, leaning forward, head forward.
- Respond with soft, warm and caring tone of voice.
- Ask about the 9 symptoms of depression.
- Ask about suicidality, and ask the 5 follow-up questions.
- Address stigma or resistance with relationship building strategies (such as PEARLS; m6) and sharing of information about depression.
- Tell the diagnosis clearly and directly, and in a supportive manner.
- Share information about depression, using simple language without jargon, short sentences, and checking for understanding.
- Explain treatment recommendations, using simple language without jargon, short sentences, and checking for understanding.
Ask about patients' perspectives on the nature of the illness and ideas for treatment, and respond with respect and acceptance of those perspectives.

REFERENCES


ADDITIONAL REFERENCES


Welcome to DocCom Module 28: Intimate Partner Violence

by Nielufar Varjavand MD and Dennis Novack MD
Facilitator Guide of this module for DocCom Residency Doctoring Curriculum

Credits:

Authors: Nielufar Varjavand MD, Dennis Novack MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Standardized Patient: Candace Robertson MPH
Clinician on camera: Nielufar Varjavand MD
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A., and Ernesto Matthias de Pina Walde
Video Assoc. Director: Dennis Novack M.D.

Version History:
3.1 - 2/28/2013 Author Revisions
3.0 - 1/19/2012 Enhanced with HTML5 code and MP4 videos
2.1 - 12/3/2010 Author Revisions
2.0 - 8/5/2009 Update to DocCom Version 4.0
1.0 - 7/16/2005

Rationale

Nielufar Varjavand MD
You are evaluating a woman with multiple complaints. Ten minutes into your exam, there’s a knock at the door. It is her companion gently asking if everything is okay and reminding her that he’ll be in the waiting room if she needs anything. Even though the interruption is minimal, you notice a slight change in your patient: she becomes distracted and looks away more. You ask her about this relationship; she remarks that he’s very good to her in that he takes her to her appointments, makes sure she is never alone, and guides her as to how to do things. Only after you persistently question her, she slowly and hesitatingly cries. At the same time, she repeatedly asserts that he “takes care of me and teaches me how to do things correctly.”

1. What will you do next? She has been scheduled for a 15 minute appointment but you highly suspect abuse.

2. What must you ask about?

3. Do you have any legal obligations in dealing with the abuse?

4. What can you offer her?

5. What do you document in the chart?

**Key Principles:**

1. Intimate partner violence is common, in fact equally common through socioeconomic classes, cultures, and races and. Abuse is often missed in clinical practice.

2. Abuse victims rarely complain of abuse, but they do often complain of multiple somatic problems and give a history of injuries.

3. Abused patients often have associated psychological issues.

4. The health care provider’s words are critical in moving patients from being victims to becoming survivors of abuse – the key is empowering patients rather than telling them what to do.

5. Understanding each patient’s unique situation is critical to therapeutic planning.

Helping patients overcome abuse may take months or years.

**Learning goals:**

At the conclusion of this module, you will be able to:

1. State the prevalence of intimate partner violence in clinical practice.
2. Describe the severe detrimental impact of violence not only on the victim but also on the family unit.
3. List the multiple ways intimate partner violence affects how patients present to their practitioners.
4. List the principles of helping patients move from victim to survivor of abuse.
5. Use appropriate communication behaviors to respond to patients when you discover domestic violence.
6. List interventions that may make the situation worse, and help patients avoid them.
7. Name community resources and describe how to utilize them on behalf of patients who are victims of domestic abuse.

**PREVALENCE**

Intimate Partner Violence is serious and widespread. It cuts across all socioeconomic groups, cultures, ages, and gender identities.

In 2005, the CDC’s annual random telephone survey of non-institutionalized US persons > 18 years included an optional Intimate Partner Violence (IPV) module. Of the 70,156 respondents, 24% of women and 11% of men had lifetime IPV victimization. Nearly one in four women in the United States reported experiencing violence by a current or former spouse or boyfriend at some point in her life. (Adverse Health Conditions and Health Risk Behaviors Associated with Intimate Partner Violence; United States, 2005 CDC. MMWR Weekly. February 8, 2008 / 57(05);113-117. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm)

Older medical studies show similar demographics. A random sample of women aged 18-46 from three public hospital primary care clinics (n=734) who were questioned about their history of physical, sexual, and psychological abuse reported a 15% prevalence of recent (within the last 12 months) abuse by an intimate partner and a lifetime prevalence of 51% (1). A self-reported survey presented to all adult women seeking care from a family practice clinic in the Midwest (n=394) showed a 22.7% prevalence of physical assault by their partners within the last year and a lifetime rate of 38.8% (2); another self-administered survey of all patients randomly presenting to three university-affiliated internal medicine clinics in California (n=453) indicated a 14% rate of current domestic violence and a 28% lifetime rate (3). Looking at medical records of all female trauma patients presenting to an emergency department, McLeer and Anwar (4) found a 30% incidence of battery leading to their presenting symptoms. Another study of female adolescents (n=4163) found that 1 in 5 female students reported being physically and/or sexually abused by a dating partner (5).
Globally, a 2005 World Health Organization study of 24,000 women from 15 sites in ten countries reported that women who had experienced physical or sexual IPV in their lifetimes ranged from 15 percent (Japan) to 71 percent (Ethiopia), and most sites fell between 29% and 62%. (García-Moreno et al. 2005. *WHO Multi-country Study on Women’s Health and Domestic Violence Against Women.* World Health Organization.


Abuse does not have boundaries. Men who have sex with men experience violence. A telephone survey of 2880 men from 4 cities from 1996-1998 found a prevalence estimate of 34% for psychological / symbolic battering, 22% for physical battering, and 5% for sexual battering. (Greenwood GL et al. *Battering Victimization Among a Probability-Based Sample of Men Who Have Sex With Men.* Am J Public Health. 2002;92:1964–1969.) A self-reported, anonymous survey of 521 adolescents at a gay, lesbian, bisexual (GLB) youth rally found the prevalence of dating violence among GLB adolescents to be similar to that of heterosexuals. (6) A nationally representative telephone survey asking about lifetime experiences with domestic violence compared same-sex cohabitation with opposite-sex cohabitation and found a higher prevalence among same-sex cohabitants and specifically among gay male couples. (7) Another national sample of 283 gays and lesbians found that 47.5% of lesbians and 29.7% of gays have been victimized by their same-sex partner. (8)

When abuse occurs during pregnancy, it could have two victims. A random sample of pregnant women from two public prenatal clinics in Texas and Maryland (n=1203) found a prevalence of 16% physical and sexual abuse during the pregnancy.(9) Another self-reported survey of 6143 women in South Carolina (population-based data) noted an 11.1% prevalence of physical abuse during their pregnancy. (10)

**RAMIFICATIONS OF VIOLENCE**

Violence has many insidious consequences for the patient, always involves the family, and may produce future violence as children mature.

It is important to establish a diagnosis of abuse. When the diagnosis is missed, patients continue to suffer and may die. Patients experiencing violence may not come to you with an injury. They often appear with physical or psychological symptoms, such as anxiety, loss of appetite, pelvic or abdominal pain, headaches, diarrhea, and problems sleeping(11).

A random telephone survey of 3568 women from a US health plan (not seeking medical care nor identified as IPV in past) found strong associations between past year IPV and a variety of medical/psychosocial conditions in 18 major areas. Victims of abuse have an increased risk of depression compared to women without partner abuse (1), and are at increased risk of substance abuse and suicide (12). Abused women had a more than 3-fold increased risk of a sexually transmitted disease and a 2-fold risk of lacerations as well as increased risk of acute respiratory tract infection, gastroesophageal reflux disease, chest pain, abdominal pain, urinary tract infections, headaches, and contusions/abrasions. (Bonomi AE, et al. *Medical and psychosocial diagnoses in women with a history of IPV.* Arch Intern Med 2009; 169(18):1692-1697.)

There are ramifications beyond individual suffering, including concomitant child abuse and the potential to produce a cycle of violence in later generations (13). Children who witness IPV are more likely to exhibit behavioral and physical health problems such as the following: depression, anxiety, violence towards peers; attempting suicide, abusing drugs and alcohol; other high risk behavior. (Graham-Bermann SA, Seng J. 2005. Violence exposure and traumatic stress symptoms as additional predictors of health problems in high-risk children. J Pediatrics 2005;146(6):349-354.) A study of 8629 participants showed a statistically significant graded relationship between the number of childhood violent experiences and risk of IPV. Physical abuse during childhood increases the risk of future victimization among women and the risk of future perpetration of

When violence occurs during pregnancy, the effects can be even more pronounced, such as preterm delivery (14), cesarean delivery, hospitalization for complications (10), and impairment of coping mechanisms.(9)

Intimate partner violence is costly. One study revealed that a large health plan spent about $2000 more per patient for abuse victims, who had more hospitalizations, general clinic use, mental health services, and referrals (15). In another study in which residents evaluated standardized patients for various clinical scenarios, residents missed the history and ordered unnecessary tests to evaluate the abused patients. Furthermore, residents who missed the DV diagnosis spent nearly twice as much working up their patients (16).

UNDERRECOGNITION OF IPV

Intimate Partner Violence is often unrecognized in general practice, emergency centers and in hospital settings. When it is recognized, clinicians often do not respond effectively.

We tested 71 residents in a multi-station standardized patient exercise where one station depicted a scenario common to abuse victims—a woman presenting with chronic headaches, who, if asked appropriate questions, would admit to having an abusive partner. Forty (56%) residents correctly diagnosed IPV. Still, the majority gave inappropriate (even dangerous) treatment recommendations (16).

There are many reasons for under-recognition of IPV. Many clinicians do not screen for abuse, or do not have a high index of suspicion. Many clinicians are uncomfortable asking questions about abuse. Many fear that if they ask about abuse, they won't know how to respond. On the patients’ side, abused women are often embarrassed or ashamed by the abuse and will not readily admit the abuse to their practitioners. They often present with a variety of somatic symptoms, and clinicians can often get sidetracked working these up. Many women are afraid to admit the abuse: they may have been threatened with even more violence if they reveal the abuse to anyone. Many are ambivalent about their relationships with their abusers, hoping that things will turn around; some feel that they are at fault or are bad, or deserve the abuse. Many women have concomitant mental health problems, such as depression or alcohol abuse, that cause their own problems and may distract from the diagnosis of abuse. To admit abuse, a patient must feel completely trusting of clinician, feel that there is time to talk about it, and that the clinician cares.

SCREEN FOR IPV - IPV IS "SECRET"

Screen for violence by asking direct questions. As of 2013, the U.S. Preventive Services Task Force (USPSTF) recommends "that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation). This recommendation applies to women who do not have signs or symptoms of abuse.” (28)

As long ago as 1992, the AMA recommended... “to routinely screen (women) for victimization—including intimate physical and sexual assault, in initial and ongoing assessments.”(17)

Unfortunately, routine screening for IPV is infrequent (10%-25%), even in states where screening is mandatory (18, 19). Yet, clinicians believe it is part of their role to assist victims of IPV (20).

It is important to ask straightforwardly about abuse. Abused women feel a good deal of guilt,
shame and fear about their situations, and are understandably reluctant to disclose. Normalize questions about domestic violence by including them with other "routine" psychosocial history questions like smoking and drinking. Or bring up abuse while asking about other safety questions, such as seat belts or weapons (21). Experts suggest questions like these:

"I see many patients who are dealing with abusive relationships. Some are too uncomfortable to bring it up so I ask about it routinely. Are you involved with someone who physically or emotionally hurts you?" (22).

"Who do you live with? How do you get along? How do you/your partner manage your anger? Do you ever have physical fights?"

As discussed earlier, many women may be reluctant to reveal the abuse; don’t expect victims to immediately open up to you. If a patient seems hesitant, or equivocal, or looks down when she answers, or changes the subject, or says something like,

"I’m just trying to be a good wife,”

you can gently encourage her:

"It sounds like it’s hard for you to talk about this.”

If she nods in assent, you can reassure her of confidentiality, and your willingness to listen. Use attentive silence (Module 6) to give her a chance to gather courage to respond.

Beyond routine screening, suspect abuse when women present with symptoms that seem stress related, such as headaches, muscle aches, fatigue ... or if they have multiple somatic complaints with negative work-ups for organic causes. Beyond diagnosis, your most important role is to provide “information, support, and a safe environment” for discussion whenever the patient is ready (23).

**WHAT DO YOU ASK ABOUT ONCE THE PATIENT DISCLOSES VIOLENCE?**

It is important to understand something about the patient’s background and the development of the abusive relationship, before you can begin to make suggestions.

Ask, "Can you tell me something about your life, what your childhood was like, how you got into this kind of relationship? Tell me something about your partner.”

Many abused women grow up in abusive homes. As children many have witnessed violence against their mothers and are often victims of physical and emotional abuse themselves. Often a parent is an alcoholic.

Ask, "Many women who are victims of intimate partner violence have experienced sexual or physical abuse growing up. Has that happened to you?”

As children trying to make sense of their lives, they assume that they are being punished because they are bad. They grow up with the sense that they are bad, that they are undeserving, not good enough, not intrinsically lovable, that life is uncontrollable. They grow up expecting to be rejected and hurt. Many fall victim to the common psychological defense of “repetition compulsion.” They run away from home at an early age to be with a man that they think will treat them with respect. They may know that there may be problems with the relationship but feel that if they love the new partner enough, they can reform him. Too often, these partners become abusers. Their sense of lack of choice is compounded by their ambivalence and confusion. Abusers often take their victims through a cycle of violence-honeymoon where immediately after an outburst of violence, the
abuser apologizes and is extremely caring towards the victim. This may last for some time; then the pattern of abuse gradually escalates. Abused women feel that their partner loves them, and needs them, and they often have strong feelings of love and need as well. After the apology the victims start to hope again and positive feelings may resurface. When the abuse recurs, all of the negative feelings about self, the sense of helplessness, and the positive feelings for the abuser all combine to paralyze the victim's will. They see no way out. Also, practically, they may have few choices. They are often financially dependent on the abuser, have children in school, few social and family resources, and feel if they leave they will have nowhere to turn.

Reading narratives written by survivors of abuse can give you insight into the worlds of abuse victims.

---

**Key Questions**

There are other key questions you must ask once you learn about abuse.

**Ask about her thoughts and feelings, and any plans.** It is important to understand your patient's reactions to her situation. She may blame herself or feel she deserves the abuse. She may be desperate but sees no way out. She may have thought about leaving in a tentative way, or she may have decided to do so but needs help. Ask gently about what she thinks and feels about her situation and about any plans she may have made.

**Ask about safety.** First, assess if she is in immediate danger once she leaves your office. Has the pattern of abuse escalated lately? How severe have been the physical injuries? Has she had to go to the ER? If the abuse has not escalated, ask about the possibility of serious abuse in the future, i.e., does the abuser have a weapon?

**Ask about child abuse.** Ask if anyone else is being maltreated--as children often witness abuse or are victims themselves. If there is concomitant child abuse, you have a legal obligation to report this.

**Ask about mood.** Depression and suicidal ideation is common among victims of abuse (1, 12). Depression can paralyze the victim’s will, and make her situation seem more hopeless than it is. Adequate treatment of depression often enables the victim to think more clearly, improves her self-esteem, and lessens her tolerance of abuse. If you are referring her to a therapist, be sure to cite abuse as a reason, for a possible stigma of mental incapacity may be used by the abuser in custody battles later.

**Ask about substance abuse.** Many women will try to escape the pain of abuse by turning to drugs or alcohol. Substance use and abuse only complicates the situation and keeps her trapped. If she is abusing substances she will need treatment for that problem as well as her abuse.

---

**WHAT DO YOU HAVE TO SAY ONCE THE PATIENT DISCLOSES VIOLENCE?**

It is important to say several things:

1. “This is wrong.”
2. “It’s not your fault.”
3. “You are not alone.”
4. “You have a choice.”
1. “This is wrong.” The personal and emotional history of IPV victims often instills the errant belief that abuse is what life has to offer for them. Your strong statement, “This is wrong. No one has the right to put a hand to you, no matter what!” can shake the abused woman’s world, and be the beginning of her thinking differently. Empower the victim by telling her she does not deserve such treatment. It is important not to seem like you are scolding her (“Why do you stay with him?”) (22)

2. “It’s not your fault.” Too often, abused women blame themselves for the abuse, saying things like, “I should have had his dinner ready on time. It is the least I can do – he works so hard.” “If only I were a better wife, things would be different.” The abusers often shift the blame onto the victim and make verbally abusive statements about the victim’s worthlessness. You must reinforce the notion that abuse is not the victims’ fault. “Please don’t blame yourself. Nothing about this is your fault. Nothing you do should provoke him to hit you.”

3. “You are not alone.” Abused women feel isolated and alone. This is frequently reinforced by the abuser, who has over time systematically worked to cut off contacts with the victim’s family and friends. Let the patient know that domestic abuse is all too common, and that there is a good deal of support available in the community. Let her know that you will be available to work with her to help her to make choices for her life.

4. “You have a choice.” Women in abusive situations often feel trapped. They see themselves as victims of fate without choices. The great insight that allows them to begin the first steps away from being a victim of abuse to being a survivor starts when they realize that they actually have choices in their lives. You can help them come to that realization: “You don’t have to live like this. You can choose another course. There are hard choices, but there are choices, and you can make them. What have you thought about?”

COUNSELING

Urge the patient to seek counseling. Arrange for counseling immediately if needed. Do not tell people to leave their partners.

If it seems too dangerous to return home today, you must actively intervene and ask if she would be willing to see a counselor immediately. Many hospitals and communities have such counselors available, and it is imperative for you to know of these resources.

Make a statement of concern: "I admire your courage in telling me all this. From what you’ve told me about your husband’s recent behavior and his threats, I’m really worried about your going home today. Would it be ok if I called a domestic violence counselor who you could see immediately?"

If immediate danger is ruled out, referring patients for counseling is the core of IPV management (24). Make small educational brochures with emergency numbers of counselors, hotlines, and shelters available in your room and in your women’s bathroom. Thus, the patient can discreetly read and carry these small cards on her. Tell the patient about specific resources and people she can call as soon as she feels safe to do so. Once referred, the counselor will then assess further safety issues and educate her about her options.

While it is reasonable to ask the patient if she has thought about leaving the abuser, it is ill-advised to recommend that she leaves, for many reasons. The first is that women start the healing process by realizing they have a choice. They are used to following orders from an authority figure. If you tell a woman to leave, she might just do so because you said it, which could precipitate a crisis in her life and endanger her. It is important to remember that leaving is the most dangerous time for a victim of abuse. Also, if she leaves precipitously, she may have limited
choices and financial support. Some women suddenly become homeless when they leave.

To succeed, she must plan carefully. If she asks your advice about leaving and wants to plan to do so, educate her to plan ahead: set aside some money regularly, copy all important records, disclose the abuse to family and friends in order to gain support and identify where she can stay once she leaves, alert company and coworkers about the existence of abuse. Remember that many women may try to leave many times before they succeed, and many women are not ready to leave yet, still hoping to salvage the relationship. If you show that you are judgmental or frustrated at a patient’s unwillingness to take necessary steps, it will undermine her trust in you and your ability to help her.

Another generally accepted contradiction of treatment is recommending couples counseling (24). Abusers generally become angry when they learn the victim has revealed the abuse, and the violence may escalate. Also, abusers seldom benefit from this form of counseling. http://www.endabuse.org/resources/ provides a comprehensive review of resources.

AnnotatedVideo (not shown in print-out text)

WHAT DO YOU DOCUMENT IN THE CHART?

The doctor’s notes are often the only other evidence of abuse besides the victim’s voice, as there are often no witnesses to abuse (25).

Legally appropriate chart documentation could be an invaluable asset to the patient in court. The National Institute of Justice has put out a report regarding documenting domestic violence. They note the following: When examining a victim, if there are injuries, take pictures, draw body maps, and describe the stage(s) of healing. Write who committed the injury and with what instrument. Describe the facts; do not write “patient claims or patient alleges” as this may introduce incredulity in the courts. As always, write legibly. (26)

Legal issues

Make sure you are aware of your state’s laws about abuse.

In addition to providing general standard medical care, clinicians treating victims of abuse may have legal obligations. As of March 1994, all but five states (Alabama, Louisiana, South Carolina, Washington, and Wyoming) have laws that to varying extents require reporting of injuries involving a weapon or a crime.

As of 2001, six states (California, Colorado, Kentucky, New Hampshire, New Mexico, and Rhode Island) specifically require reporting domestic violence. Still, reporting may have varying reasons: Rhode Island requires reporting for data collection only whereas California requires reporting to the police (27).

Since local laws vary state by state, providers must know local reporting laws or possibly be held liable for neglect. National District Attorneys Association has a list of state laws regarding domestic violence. See http://www.ndaa.org/pdf/the_voice_vol_1_no_3_2006.pdf

CONCLUSION
**Intimate Partner Violence is widespread among women seeking medical care.** It affects women’s overall well-being, any children involved, and society (by increasing cost of health care). As clinicians, there is much that we can do: we can help by screening for abuse, empowering and educating the victims, and referring them to specialized domestic violence counselors.

**Websites to Join:**

To join a listserve of clinicians devoted to education, research, and ending abuse, write to violence-ig@list.sgim.org


---

## RELEVANT BEHAVIORS

**ASK:**

- about abuse directly
- about duration, pattern and severity of abuse
- about immediate safety
- about patient perspective / view / thoughts, feelings and mood
- about childhood history of abuse
- about child / elder abuse
- about substance use

**SAY:**

- “This is wrong.”
- “It’s not your fault.”
- “You don’t deserve this.”
- “You are not alone.”
- “You have a choice.”
- offer empathic responses and understanding
- suggest referral for counseling
- assure her of your respect and your willingness to work with her to make sensible choices for her life

**DO NOT:**

- Assign blame
- Tell her to leave
- Suggest couples counseling

---

**LITERATURE REFERENCES**

LONE BEAR’S STORY

by Dennis H. Novack, M.D.

Original Publication in Medical Encounter; Volume 12 No.2, Spring 1996; used with Permission

This text is available for printout: LoneBearStory.pdf

Introduction

Three years ago last Thanksgiving I left my husband for the final time. When I left I have to admit I did not know I was leaving permanently. I was just escaping. But looking back I realize it was the first actual physical step I took to save my life. Now I see that events and people at the right times and places enabled me to take each needed step to make the final break.

History

I had been married for seven years. This was my second marriage and it was a typical domestic violent (DV) relationship with cycles of abuse and "honeymoon" periods. However, at the time of my final leaving there were no longer any "honeymoon" periods. Our marriage was mostly extended periods of silence by my husband unless he was on a tirade or other people were present.

I had left many times - sometimes for a few hours, other times overnight and a couple times for several nights. A few incidents involved the county sheriffs department. But never was anyone taken away or any follow-up done.

My husband was classified disabled and had a very modest monthly income. I was the full-time breadwinner. However, the "control" part of our relationship had progressed until my husband had full control of all our income and expenses. He drove me everywhere and the only thing I did outside of going to work was attend his son's high school athletic activities and church on Sunday.

At the time of my final leaving the severe physical violence had ceased. After a severe beating early in the marriage I filed for divorce. He then knew how much physical abuse I would tolerate. After a two-month separation with promises of a Christian home (exactly what I wanted to hear) he drew me back in.

This time my husband found I would tolerate pushes, being slammed against walls, squeezed, telephones ripped out, being confined, etc. I was isolated from friends and family. I was not only afraid of him, but embarrassed, confused, and by this time so dependent I just lived from day to day. Knowing this was not right but incapable of taking any action to get away, I was always walking on eggshells to keep from shattering the peace. I came to welcome his punishments of ignoring me for days at a time.

We attended an exclusive-membership church in Seattle where women were not allowed to speak. There was no interaction with the church outside of Sundays. He took an active "speaking" role in this church. At home I was continually preached to about not being submissive enough and did not know my "place." My faith in God was used effectively against me.

To finish this history, I am sure you know that the control issues did not just happen overnight. It continually escalated and the more I tolerated the more I lost control of my life.

At the time just prior to my actual leaving, I don't believe I was actually suicidal but I was deeply depressed. And I can honestly say I felt death probably was preferable to what my life was. My children (my only close family) had been pushed away from me. With my life far beyond my control at the time I just didn't care if I lived or died. When my husband would go somewhere, I would hope something would happen to him so he would not come home.
Leaving

I had outpatient arm surgery (work related) the day before Thanksgiving (holidays are crisis times in DV relationships). My husband was giving me my pain medication. I was sleeping most of the time. But I was so drugged I didn't realize it or care. Due to an allergic reaction to the pain medication (I have this problem with pain medication), I aroused enough to know I was not breathing properly and had severe itching.

I asked my husband to call the surgery consulting nurse but he refused. I literally had to pull myself to the telephone in the kitchen (none in the bedroom) and call. She said to immediately call 911 for paramedics or if it was faster have my husband rush me to the hospital. I had my husband talk to her as he would not respond to my plead for help. He hung up and said he would drive me, walked out to the car and waited for me. By pulling myself along I managed to get to the car. If his actions were public he always acted in a way that protected himself, i.e., talked to the nurse, took me to the hospital. But he offered no help to me.

At the hospital they treated me for a drug reaction. But the doctor asked me why there were so few pills left. I told him my husband had been giving me the medication. The doctor had my husband come in from the waiting room and asked him why he had given me so many. I can remember my husband replied "I just thought it was better for her to sleep." After a few hours in the hospital I was sent home with my husband. The doctor could have been sending me home to die.

When we returned home I waited until I felt "normal" and until my husband was not paying attention. I grabbed a few articles of clothing and walked out to the car. I managed to get in and lock the door before he came storming out. I then drove away and never went back.

It has only been through DV group counseling that I have been able to admit that his intentions may not only have been to keep me quiet but to permanently silence me. A murder threat against me telephoned to my daughter and son-in-law during the time of the divorce proceedings confirmed this.

Doctors

Doctor A:

My husband and I had the same primary care doctor. I really like him and went to him before I ever married my husband. I have since returned to this doctor as my primary care clinician. But to this day we have never discussed why my marriage to Steve dissolved.

During the marriage my doctor treated me for stomach and bowel problems, asthma, chronic sinus infections and chest pains. It seems like I was always going to him for something. He was treating all the symptoms and never finding out the real underlying cause of them.

Whenever I needed to see the doctor, Steve always accompanied me, usually even into the exam room with me. The doctor would come in, take care of me and then start visiting with Steve. Toward the end of the relationship I was constantly being monitored by Steve.

One incident I know the doctor should have followed up in private with me in some way. It was a typical doctor visit for me with Steve following me into the exam room. The doctor had completed his exam and made some comment to Steve (I do not remember what it was). But I do remember Steve replying "Maybe I should just knock some sense into her!" The doctor did respond that Steve should not make those kinds of statements because he might have to view it as possible abuse. Steve laughed and said he was just joking.

One thing my doctor did that probably helped me escape the relationship was refer me to the medical group's women's health practitioner, Marilyn. I saw her for my yearly female exams. She not only concerned herself with women's health but with the whole picture. As soon as she saw how many medications I was taking, she said I had to take charge of my life. She recommended the stress reduction classes that were available. I did not take those classes, of course, nor was DV mentioned. But because of this initial visit and following visits, I trusted her and knew she was
someone I could talk to.

After I finally left Steve for good, I changed doctors. Since our doctor still was involved with Steve and his medical history, I felt it was easier for me to change, as usual putting Steve ahead of myself.

During the DV training sessions I participated in someone asked me who initiated Steve's going into the exam room with me. This immediately made me feel like I was to blame even now after three years and all I have learned in DV group. However, it was an honest question and I am sure one not intended to make me feel intimidated. I remember the first time it happened. The nurse called me in and said "Hi" to Steve. He asked if he could come in also because he wanted to ask the doctor something. The nurse said "sure." I remember it because it was one of the times I actually realized my freedom was being diminished again. A great heaviness always settled in my chest whenever some new control happened in my life. It felt like some more of me was dying.

**Doctor B:**

My new doctor was even older than I was (I will be 50 this year). I went to him for a start-up physical and even though his manner was different I had no problem with him. Looking back I realize no questions were asked on the forms or verbally about DV or related topics.

During the divorce proceedings when I was being stalked, harassed and threatened (my daughter and grandson also), I landed in the hospital emergency room with a panic attack (severe chest pain). During my follow-up visit with my primary care doctor I told him exactly what had happened and the events causing the panic attack. He seemed embarrassed about it. He was very "nice" and as he left the room he patted me on the shoulder, told me to take care of myself and gave me a prescription for tranquilizers. Maybe it was in my record that I was going to the DV Group and had seen a mental health counselor but I don't think so. And even if it was, shouldn't he have recommended I continue with the group and counseling or have some form of follow-up?

Maybe after all the years of denial, embarrassment, etc., I expect too much of other people, especially professionals, to help me. But it was a major step for me to open up and actually be honest with someone outside of the group. I knew this but guess he didn't.

**Help**

It is only looking back on the events following my leaving that I see how the final break happened. It is very obvious to me now that there are five women that are responsible for me being where I am today, Perhaps even alive.

I left on a Friday. I went to my daughter's and year-old grandson's apartment to stay. At the time I did not realize the danger I was placing them in. After a very harassing weekend, I was confused and frightened and I knew I had to get help. Monday I called not my doctor but Marilyn, my women's health practitioner.

The FIRST WOMAN I talked to on the telephone was either the receptionist or the nurse. I do not recall which it was. But I can honestly say whoever that woman was she played a very important part in my recovery. I did not tell her exactly what happened or the significance of it, but she must have picked up the crisis in my call because she got me in that very day to see Marilyn. At this time there were no same day visits scheduled even if Marilyn happened to be in the clinic that day. So whoever that woman is, thank you. If you hadn't got me in immediately, I might not have come in at all.

That day when I saw MARILYN, I told her what had happened. I felt as if I was coming completely apart. Because of the groundwork Marilyn had laid out with me in the past, I could do all this honest falling apart in her presence. If my only resource had been my doctor, I probably would not have gone to him. Marilyn provided treatment for my physical problems, but, more important in the long run, she made me an appointment with a mental health counselor, JANE, the very next day.
The next morning, I received a telephone call from mental health encouraging me to keep my appointment with Jane. This was a very important telephone call because I was already thinking of excuses for not going. Remember for several years it had been my conditioning to not take any action on my own. Besides it was frightening and embarrassing to have to meet someone new and talk honestly about my life. The telephone call made the difference in my showing up for the appointment.

After just a few minutes with Jane, I started to feel more at ease. She had lots of tissues and had a very quiet, understanding demeanor. Whether this is something counselors learn or is Jane’s personality, I don’t know. But it worked with me. She heard the above stories and also had me talking about my dysfunctional foster home, my troubled half-brother, and my Native American heritage. She also took me to the next crucial step in my recovery. She put me in touch with the DV therapy group, which just happened to be meeting the very next afternoon.

Again, there was a telephone call the next day encouraging me to attend the group. Boy, do these workers know how we DV victims rationalize our inaction. And again, this was a real hard step for me to take. With my self esteem at an all-time low, I just did not want to see a bunch of other women in similar circumstances as myself. I especially did not want to have to admit to other people how I had let my husband hurt and control me for so long.

HILLARY AND LAURA were the counselors/leaders of the group. And what a group, not what I expected. All ages, all different stages of DV represented. It was easy to go there and see what I thought were circumstances a lot worse than mine. I had never had a gun held to my head or had young children held as bargaining power against me.

Hillary, Laura and the other women in group always pointed out when I was still putting my husband ahead of myself. They helped me understand I was minimizing the danger I was in and also that of my daughter and grandson. They also helped me learn how to protect myself. Hillary could be very direct when she thought I or another was not recognizing a dangerous situation. Laura would always be there with suggestions and help when it seemed like we had run up against a wall. They were nice and always available whenever I called, but they could be tough when necessary.

One thing I learned about myself and group sessions is that it was always easy to not go, but I was always glad after I had attended a session. Now I find myself going to a meeting occasionally, usually during a crisis or new influence in my life. I attended the meeting right after Nicole Brown’s husband was found not guilty. I found myself very angry and upset about the verdict. I believe I related it to my divorce. I felt my husband was rewarded for his abuse. In both cases, in my opinion, justice was not done.

Conclusion

During the training sessions, I was asked as a DV survivor what I thought the medical group could do to help other DV victims to speak out and get help.

My first suggestion is to get domestic violence out in the open. Domestic violence is not a dirty word unless it is kept silent within an abusive relationship. If all the survivors of domestic abuse would come out in the open as a group, I believe society would be astounded at our numbers, our ages, our incomes, our races, etc.

I always see Stop Smoking and Breast Cancer Exam posters in the clinic and exam rooms. Let’s get domestic violence posters up also. Get the information out in plain view about crisis line numbers, DV shelters and groups. If I had seen DV posters when I went in to the clinic as much as I saw the others I might have sought help sooner. Remember, I was in the clinic a lot.

If there are injuries, ask and ask again. Remember we are afraid, may not have any resources to escape or are so conditioned to deny even to ourselves the situation we will not be honest with the question. But if the opportunity is always given, there may come the time when the victim reaches out for help.
The same is true for new patient histories. Have the question worded somehow on the form. And remember if the spouse is with the patient (sitting together in the waiting room or at home filling the questionnaire out), the victim will no way indicate there is a problem.

Even just three years ago, domestic violence was still pretty much kept behind closed doors. But public awareness has been greatly heightened since then, in part because of the Nicole Brown/Ronald Goldman murders and court case. There seems to be many books, newspaper, articles, television movies, etc., addressing DV. But I still hear people asking how an intelligent woman can stay in such a relationship.

I guess unless you have actually been a domestic violence victim it is hard to understand the pain, the fear, the numbness that creeps in. Remember the abuser is usually someone we have loved and "hope springs eternal." But please don't discourage any victim who reaches out in any way for help. It might be the only time she ever gets the chance.
Rationale

William Clark, MD

The Patient's View

Julian Bird, MD, (see module 6) plays the patient

The Doctor's View

William Clark, MD

Questions for Reflection:

1. How will your past experience with alcohol use problems in family, friends or patients affect your caring for future patients with alcohol problems?

2. Recall encounters with patients with alcohol problems—were there moments when you interacted less professionally than you would wish?

3. Ample evidence exists that dependent alcohol users cannot exert full control over their intake. What shapes your attitudes about whether you fully accept this evidence?

4. Patients whose lives are falling apart because of alcohol use seldom accept clinician recommendations. How do you feel about this?
Key Principles:

1. Alcohol use problems exist on a continuum, with *alcohol dependence* on the severe end, *at-risk alcohol use* at the other, and *alcohol abuse* in between.

2. Effective clinicians know the NIAAA safe (moderate) drinking limits and talk with patients about them.

3. Patients consistently minimize and cover up alcohol problems (both consciously and unconsciously), and clinicians delay action because intervention may be complex or difficult to implement.

4. Reconciling differences in clinician and patient perspectives by using evidence-based behavior change counseling skills is effective.

Learning goals:

At the conclusion of this module, you will be able to:

- Demonstrate strategies and skills for assessing alcohol use.
- Describe differences between *alcohol dependence*, *alcohol abuse*, *at risk* alcohol use, and moderate drinking (within NIAAA safe limits).
- Demonstrate communication skills that minimize patient defensiveness, for asking questions, making recommendations and adjusting goals.
- Demonstrate the use of communication skills that differ according to patients' willingness to change.

INTRODUCTION

*Alcohol use disorders* afflict 20 percent or more of adults and lead to tragic family and social problems, injuries, and death. Most clinicians feel inadequately prepared to interact with affected patients, and many express feelings of dismay at having to do so. Screening and assessment improves detection, and counseling improves patient health and clinician satisfaction with their encounters. Patients with alcohol use disorders suffer from toxic brain effects and from the debilitating psychological effects of isolation and poor social functioning, as well as emotional and physical violence to strangers, family members, and other loved ones. Helping them to change their drinking behavior requires that clinicians use specific interview techniques for responding to defensiveness and for encouraging change. This module defines and explores the spectrum of *alcohol use disorders*, and suggests ways to promote a therapeutic relationship despite patient impairments in thinking and behavior.
Using evidence based behavior change strategies, students and seasoned clinicians in primary care or specialist practices can move from common feelings of dismay and begin to celebrate the successes they will foster after study and skills practice.

We include an APPENDIX that includes both the AUDIT questions and reproductions of the Tables found in the main text section.

CONTINUUM OF ALCOHOL USE DISORDERS

Alcohol use problems exist on a mild to severe continuum, and generate another continuum of physical and psychosocial consequences. Structured screening is essential, and diagnosis may be elusive because of denial or a reticence to reveal information. Nevertheless, experts agree on an evidence-based classification system that is useful in guiding clinician actions.(18)

The term “alcoholism” is used loosely, usually referring to persons with an alcohol use disorder of unspecified severity. The following pages present clinically useful definitions. More extensive discussion and details of classification are in reference papers and in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV.

Healthy alcohol use

More than 50% of US adults abstain or drink less than one drink monthly. Thirty per cent of adults drink more than “safe limits.” Of this group, roughly 10% will manifest alcohol abuse and another 10% alcohol dependence, at a given point in time. (15,18)

NIAAA Safe Drinking Limits(16)
The NIAAA expert panel declares that “safe limits” for men are 14 or fewer drinks a week and no more than 4 drinks in a day. For women and those over age 65, they specify limits of 7 per week and 3 drinks in a day.

Moderate Drinking.
Expert consensus holds that "moderate drinking" is defined by low quantity of intake (<14 weekly for men and < 7 for women), a social setting for drinking, and little intoxication (not more than 4 drinks per occasion for men and 3 for women). Drinking above these limits is variously called “at risk”, or “hazardous,” and is likely to cause harm, according to long-term studies.(1,7)

Standard drinks. (3,16)
A “drink” is 12 oz. beer, 5 oz. wine, 2-3 oz. of cordial or aperitif or 1.5 oz. (bar shot) of liquor or brandy; and each standard drink contains ~ 0.6 oz of alcohol. Alcohol contents are approximately as follows: beer 5%, wine 12%, and liquors 40%.* Alcohol is absorbed quickly from an empty stomach; but even when taken with food, all the alcohol in drinks is absorbed.

*(12 oz beer x .05 (5%); 5 oz wine x .12; 1.5 oz liquor x .40; = .6oz ).

Alcohol dependence

Alcohol dependence is a severe disease manifested by multiple and persistent life problems, with or without the brain disorder of physical dependence.(18)

Alcohol dependence occurs across cultures and nationalities. A striking 5-10% of American adults
develop this syndrome. Individuals with it suffer medical and psychosocial consequences from uncontrolled use. Importantly, the diagnosis of alcohol dependence may occur without the brain disorder of physical dependence.

Patients with alcohol dependence are preoccupied with drinking, spend less and less time on other life activities and continue to drink despite life-threatening medical and psychosocial consequences. They develop a distinctive interactive style, hiding important facts, defending their “right” to drink, and responding to simple inquiry with hostility and reticence. Patients usually make repeated attempts to cut down or quit alcohol, and many will also develop physical dependence, with withdrawal symptoms.

Table 2: Symptoms of alcohol use disorders. (16-adapted)

<table>
<thead>
<tr>
<th>Symptoms of Alcohol Abuse</th>
<th>Symptoms of Alcohol Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes to <strong>one or more</strong> of the questions below, the patient has <strong>alcohol abuse</strong>. In either case, proceed to assess for dependence symptoms.</td>
<td>If yes to <strong>three or more</strong> of the questions below, the patient has <strong>alcohol dependence</strong>.</td>
</tr>
<tr>
<td>In the past 12 months, has patient’s drinking <strong>repeatedly</strong> caused or contributed to:</td>
<td>In the past 12 months, has the patient-</td>
</tr>
<tr>
<td>- <strong>risk</strong> of bodily harm (drinking and driving, operating machinery, swimming)</td>
<td>- <strong>not been able to stick to drinking limits</strong> (repeatedly gone over them)</td>
</tr>
<tr>
<td>- <strong>relationship</strong> trouble (family or friends)</td>
<td>- <strong>not been able to cut down or stop</strong> (repeated failed attempts; may include abstinence periods)</td>
</tr>
<tr>
<td>- <strong>role failure</strong> (interference with home, work, or school obligations)</td>
<td>- <strong>shown tolerance</strong> (needed to drink a lot more to get the same effect)</td>
</tr>
<tr>
<td>- <strong>run-ins</strong> with the law (arrests or other legal problems)</td>
<td>- <strong>shown signs of withdrawal</strong> (tremors, sweating, nausea, insomnia, if trying to quit / cut down)</td>
</tr>
<tr>
<td></td>
<td>- <strong>kept drinking despite problems</strong> (physical, e.g., blackouts, overdose, gastritis, liver trouble; psychological, e.g., anxiety, depression, request for psychotropic meds)</td>
</tr>
<tr>
<td></td>
<td>- <strong>spent a lot of time drinking</strong> (or anticipating or recovering from drinking)</td>
</tr>
<tr>
<td></td>
<td>- <strong>spent less time on other matters</strong> (activities that had been important or pleasurable)</td>
</tr>
</tbody>
</table>

**Alcohol abuse**

People with alcohol abuse have less intense and less pervasive symptoms.

On the continuum, alcohol abuse falls toward the center, with moderate to severe consequences. Alcohol abuse is a

“**maladaptive pattern of use leading to impairment or distress, manifested in a 12 month period by one or more of the following: failure to fulfill role obligations; recurrent use in hazardous situations; legal problems; continued use despite alcohol-related social or interpersonal problems.**”

What distinguishes alcohol abuse from alcohol dependence is **not the nature** of problems, but the **frequency and pervasiveness** of problems. Both abuse and dependence result in health and legal problems, family dysfunction, and impaired performance at school or work.

When patients show neurochemical changes and symptoms of physical dependence, the
appropriate diagnosis is alcohol dependence, not alcohol abuse. (3)

Table 2: Symptoms of alcohol use disorders. (16-adapted)

<table>
<thead>
<tr>
<th>If yes to one or more of the questions below, the patient has alcohol abuse. In either case, proceed to assess for dependence symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 12 months, has patient’s drinking repeatedly caused or contributed to-</td>
</tr>
<tr>
<td>-risk of bodily harm (drinking and driving, operating machinery, swimming)</td>
</tr>
<tr>
<td>-relationship trouble (family or friends)</td>
</tr>
<tr>
<td>-role failure (interference with home, work, or school obligations)</td>
</tr>
<tr>
<td>-run-ins with the law (arrests or other legal problems)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes to three or more of the questions below, the patient has alcohol dependence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the past 12 months, has the patient-</td>
</tr>
<tr>
<td>-not been able to stick to drinking limits (repeatedly gone over them)</td>
</tr>
<tr>
<td>-not been able to cut down or stop (repeated failed attempts; may include abstinence periods)</td>
</tr>
<tr>
<td>-shown tolerance (needed to drink a lot more to get the same effect)</td>
</tr>
<tr>
<td>-shown signs of withdrawal (tremors, sweating, nausea, insomnia, if trying to quit / cut down)</td>
</tr>
<tr>
<td>-kept drinking despite problems (physical, e.g., blackouts, overdose, gastritis, liver trouble; psychological, e.g., anxiety, depression, request for psychotropic meds)</td>
</tr>
<tr>
<td>-spent a lot of time drinking (or anticipating or recovering from drinking)</td>
</tr>
<tr>
<td>-spent less time on other matters (activities that had been important or pleasurable)</td>
</tr>
</tbody>
</table>

At risk or hazardous alcohol use

The alcohol use disorder of at risk drinking (or hazardous drinking) includes both drinking in unsafe situations, and drinking above recommended limits, without important or sustained life problems.

On the mild end of the continuum are “at risk” or “hazardous” users. “At risk” drinkers use alcohol above the recommended amounts (see healthy use) (16), but do not yet have important negative consequences. "Hazardous" users may use alcohol in high-risk situations such as when taking medications that interact with alcohol, during pregnancy, or while operating a chainsaw. Clinicians should intervene with such drinkers on the basis of the risks associated with higher quantity or the risky situations. In contrast, interventions with patients with abuse or dependence are made because of negative consequences.

Clinicians need data about both quantity and consequences, and the meaning of “quantity” remains unclear until they obtain a picture of adverse consequences or lack thereof. Most people who experience serious life consequences use excessive amounts; but the intensity of clinical interventions should be based on the severity of problems, not on the amount consumed.(3,10,18)

Pathophysiology

The pathophysiology of alcohol use disorders is a failure to consistently limit drinking. “Denial” severely limits normal social interactions and interferes with effective clinician care.

Individuals modulate their drinking according to feedback from internal states such as shame or
hangover, and external feedback such as reprimands, criticism, and sanctions. The interplay of genetic, physiological, psychological and social factors determines an individual’s success or failure in limiting use.

When a drinker cannot consistently limit use, the brain effects of heavy use facilitate a vicious circle of using more, developing problems, and the role of the intoxicant. This discounting of the negative effects of alcohol is often called “denial.” Denial builds on both neurochemical and psychological changes.

Heavy intake produces memory deficits and other cognitive problems, as well as the dysphoric effects of hangover. The brain can adapt, becoming “tolerant”, enabling even heavier drinking without overt intoxication. Friends and family resent the apparently voluntary nature of over-indulgence. Drinkers make excuses for their behavior, direct blame onto others, and show hostility whenever sensible limits are discussed. They become adept at ignoring reality and suppressing negative feelings. Social dynamics become increasingly unhealthy and uncertain. The heavy drinker selects friends and partners who tacitly agree to overlook intoxication and its consequences. Denial is not only a powerful mediator of patients’ interpersonal difficulties, but also of clinician difficulty in establishing a diagnosis.

With or without actual physical dependence, the problem drinker becomes emotionally isolated. This may be so extensive that family and friends sometimes feel that two separate individuals inhabit the same physical body, and one of them is mysterious and unfathomable.(3)

### Pre-Screening

Information and data about patients’ alcohol use and misuse affects the diagnosis and management of all other medical problems and every aspect of medical care.

Prescreen new patients with a single, simple question about alcohol (16):

“Do you sometimes drink beer, wine, or other alcoholic beverages?”

If the answer is “No,” leave this topic. The abstinent subgroup with past problems often discloses this spontaneously, although the clinician may want to explore selectively why a patient is abstinent.

A “Yes” answer should be followed up with a screen for at-risk drinking, abuse and dependence. Remember that certain patients may be at-risk with low intake, because of pregnancy, a medication interaction, a health condition or a work issue.

Typically, conversations about alcohol begin “on the wrong foot,” because of the dynamics that produce denial. All patients who use too much alcohol have high levels of ambivalence and resist talking seriously about drinking. Studies show that encounters that employ skills discussed in the following sections are more critical to success than getting any one encounter “exactly right.”(2,3,12,13,17,24)

Show interest in the patient as a person with voice tone, gestures, and words that convey care and concern. Remain sensitive to cues patients put out that might signal issues about trust or veiled concerns. A possible empathic response to irritability or suspicion might sound like:

“Many people are concerned about these questions,” or

“Let’s back up a moment, as I’d like to explain why drinking might be important to your care.”

When patients seem vague, put off, confused or appear to be attacking the clinician, respond with a statement that reflects back the content of the patient’s utterance.
"I hear some concern or irritation in your voice." or "This line of questions seems to be confusing to you."

**DIAGNOSIS**

Confirm the presence of an *alcohol use disorder* through assessment of symptoms and evaluation of clues. Despite scant or imprecise information, tentatively decide whether the evidence best fits a diagnosis of *moderate drinking, at-risk drinking, alcohol abuse or alcohol dependence* (with or without physical dependence).

Always begin with evidence-based screening strategies.(5,9,16,20,22) Refrain from giving reassurance or answering questions about diagnosis or treatment during the assessment process. Allot time not only for investigation of physical, psychological and social symptoms, but also for discussion about the pros and cons of drinking and patients’ perspectives about quitting alcohol.

Clinicians do not have to be certain of the precise *alcohol use disorder* diagnosis, since all interventions will address similar dynamics about relationship, trust and the process of changing drinking behavior. Over multiple encounters, clinicians improve diagnostic

Subsequent pages and the videos in this section illustrate these principles.

**Intoxication, tolerance, withdrawal**

In clinical settings alcohol on the breath, intoxication and tolerance mean a high likelihood of an *alcohol use disorder*, and its severity is determined by further investigation. For practical purposes, withdrawal symptoms *always* mean *alcohol dependence.*(3)

**Alcohol on the breath** always demands further investigation, because it means the patient has recently had several drinks. If easily smelled, the alcohol level (BAL) is likely greater than 0.125 g/dl, and a less dramatic odor suggests BAL of 0.07 to 0.10 g/dl. Zero .08 is the legal level for driving. The BAL declines in linear fashion, at approximately .015-.020 g/dl/hr.

Healthy drinkers do not attend clinical appointments with alcohol on their breath. Even in the Emergency Department, someone “under the influence” is likely to have an *alcohol use disorder*, because only a tiny proportion of ED patients are healthy drinkers who drank “one too many”.

In medical encounters any sign of *intoxication*—most prominently slurred speech, incoordination or emotional lability—prompts a tentative diagnosis of *alcohol use disorder*, until proven otherwise.

**Tolerance** is present if an odor of alcohol is apparent in the absence of intoxication - a person can look normal with an alcohol level of 0.400 g/dl, or even higher. Tolerance is caused by heavy drinking lasting at least several days (usually weeks), indicates brain adjustment to alcohol, is inevitably toxic, and usually means *alcohol dependence*.

**Withdrawal** symptoms—most prominently, anxiety, sweating, tremor and tachycardia--do not happen overnight, or on a short binge. Brain chemistry changes over periods of weeks and usually years of heavy drinking. The worse the physical dependence, the more quickly withdrawal symptoms develop after the “last” drink. The symptoms cause an intense craving, and a few trials convince the person that a drink is an effective antidote. People begin to save a beer in the refrigerator, or a drink under the bed in anticipation of shakes and anxiety during the night or in the morning; this drink is the *eye-opener*. In extreme cases people try continuously to dampen the withdrawal sickness and then drink around the clock, never really sleeping or eating. Dependent individuals in this situation can develop the potentially lethal complication of delirium tremens.
**Structured Screening: AUDIT /CAGE**

Clinicians are unlikely to discern *alcohol use disorders* without a structured screening strategy, and currently miss 60% to 80% of cases. The AUDIT and the CAGE are effective simple screens.

Consistent use of a validated strategy is a powerful determinant of clinical effectiveness. One carefully validated screening strategy is the 10 question **AUDIT**, also available in Spanish. It can be self-administered in a waiting room; it is sensitive throughout the spectrum of unhealthy drinking\(^{(10)}\); and it is the best instrument for identifying hazardous drinking (sensitivity 57-97%, specificity, 78-96\%)\(^{(16)}\).

Alternatively, many clinicians begin with the simple first AUDIT question\(^{(9,20)}\):

> "How many times in the past year have you had 5 or more drinks in a day (for men; or 4 or more drinks for women)."

(Positive screen is at least one day with 5 or more drinks [4 for women])

This closed question rather than open ones (Module 8) is helpful here. If patients answer open-ended questions vaguely, forcing the interviewer to ask clarifying questions, they feel accused of lying and become defensive.

If this response is positive, quantify the drinking behavior. Determine a weekly average by asking:

> "On average, how many days a week do you have an alcoholic drink?" and "On a typical day, how many drinks do you have?"

Record and monitor heavy drinking days and the weekly average over time.

The four-question **CAGE** test (Table 1, and **Appendix**) is a validated screen, initially designed to test for alcohol dependence. However, CAGE is a good way to begin a conversation without fostering undue defensiveness, and easy to use\(^{(3)}\). If two responses are positive, it is 60%-95% sensitive and 40-95% specific for alcohol dependence, depending on the population screened. CAGE is less accurate for women and African-Americans. To better detect at-risk drinkers, the CAGE questions can be combined with consumption questions from the AUDIT\(^{(10)}\). Laboratory testing is of little use for screening purposes\(^{(5)}\).

**Table 1. CAGE screening for dependence symptoms.**

1. Have you ever felt that you should **Cut down** on your drinking?
2. Have people **Annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **Guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (**Eye opener**)  

AnnotatedVideo (not shown in print-out text)

---

**Other clues**

Unsolicited comments about alcohol, legal issues, family comments and other evidence require more intensive data-gathering.
You should follow up patients' spontaneous mention of “partying,” hangover, blackouts or withdrawal symptoms. The same is true for a positive family history, arrests for driving while intoxicated, spouses or friends who confide about problems, and prior medical records that indicate alcohol-related problems. Interviews with family, nurses, or social workers, and records from other clinicians or hospitals may contain unanticipated information that establishes a diagnosis.

**ASSESSMENT AFTER POSITIVE SCREEN**

Additional assessment is required after a positive screen or to follow up another clue. Ask about typical symptoms, the pros and cons of drinking and readiness to cut down or quit. (16)

Patients with problems minimize intake and consequences, and may lie outright. When inquiry provokes defensiveness, many clinicians experience frustration, often because of interactions with previous patients. This puts them out of balance and may make expression of caring difficult. Effective clinicians remain mindful of their feelings and learn ways to respond positively.

If any screen is positive or worrisome, or if patients spontaneously disclose drinking that exceeds safe limits or if another clue (perhaps from physical exam or the family) is present, take more history. Ask about the issues listed in Table 2. Ask about the patient’s perspective (Module 9) on drinking and consequences.

**Table 2. Symptoms of alcohol use disorders. (16-adapted)**

If yes to **one or more** of the questions below, the patient has **alcohol abuse. In either case, proceed to assess for dependence symptoms.**

- **In the past 12 months, has patient’s drinking** repeatedly caused or contributed to-
- **-risk** of bodily harm (drinking and driving, operating machinery, swimming)
- **-relationship** trouble (family or friends)
- **-role failure** (interference with home, work, or school obligations)
- **-run-ins** with the law (arrests or other legal problems)

If yes to **three or more** of the questions below, the patient has **alcohol dependence.**

- **In the past 12 months, has the patient-**
  - **not been able to stick to drinking limits** (repeatedly gone over them)
  - **not been able to cut down or stop** (repeated failed attempts; may include abstinent periods)
  - **shown tolerance** (needed to drink a lot more to get the same effect)
  - **shown signs of withdrawal** (tremors, sweating, nausea, insomnia, if trying to quit / cut down)
  - **kept drinking despite problems** (physical, e.g., blackouts, overdose, gastritis, liver trouble; psychological, e.g., anxiety, depression, request for psychotropic meds)
  - **spent a lot of time drinking** (or anticipating or recovering from drinking)
  - **spent less time on other matters** (activities that had been important or pleasurable)
Ask pros and cons of drinking

Asking about benefits and negatives of drinking provides more data, encourages reflection and builds relationship.(3,13)

Asking screen-positive patients to comment on the good things and the not-so-good things about their drinking continues the conversation. The prior “doctor-centered” (Module 5) screening and symptom questions are important for diagnosis, but they limit dialogue. A more “patient-centered” approach is to ask about patients’ beliefs about the role of alcohol.

"I'm interested in what benefits you get from drinking alcohol"

invites their perspective.

"Yes, and what else is good about drinking?" "And what else?"

Show that you sincerely wish to hear their thoughts.

Following up with asking about the "cons" invites them to reflect, and contributes valuable information, not only to assessment and diagnosis, but also to formulation and negotiation of next steps as the clinician moves toward planning interventions.

Questions about quitting enhance your understanding of patients' situations.

"If you were to quit (or cut back to safe levels), what benefits could you imagine,"

or, if appropriate to the patient,

"...what benefits did you notice during previous periods of abstinence?"

And,

"For you, what might be the negative consequences of cutting back?"

This level of conversation demonstrates interest in and valuing of the patient's perspective. The willingness to attentively listen (Module 6) contributes strongly to the ability collaboratively negotiate next steps.

Assess readiness to change

Listening to patients’ perspectives on their interest in changing, and about their perceived ability to accomplish change prepares the ground for dialogue about next steps.

Prochaska and colleagues proposed that people progress through typical "stages" on the way to successful lifestyle change(24). West(23) notes the “soft” nature of the “stages” and suggests that clinicians who affix “stage” labels may limit dialogue or fail to engage a spark of motivation in patients. We agree that conversations about readiness help patients consider health behavior change, and that avoiding stage designations is a more relationship-centered approach.(2)

Ascertain patients’ motivational readiness by asking about conviction and confidence. Conviction assesses what patients believe about the importance of adopting or changing a behavior, while
confidence assesses beliefs about success at changing. Belief about success is often referred to as “self-efficacy.”

Ask patients to help you understand where they stand by requesting that they use a numerical rating scale:

Understand patients’ beliefs by using the rating scale above. Frame questions as follows:

First--"On a scale of 0-10, how convinced are you that quitting (or cutting down) is important?"

And then--"Let's suppose for a moment that you were a 10, completely convinced that you should quit (or cut down;) on a 0-10 scale, how confident are you that you would be able to entirely abstain (or limit drinking to safe levels) for the next 4 weeks?"

In addition to assessing beliefs about change that are seldom made explicit in medical interviews, engaging patients in this dialogue provides additional information about drinking and consequences. This is true even when patients protest that they do not like to use number scales.

Usually, asking why the number the patient chose is not LOWER than the number chosen encourages patients to voice their own thoughts about change in positive terms, smoothing a transition to talking about recommendations.

**ALCOHOL COUNSELING PRINCIPLES**

Alcohol counseling is a common task facing clinicians in office and hospital settings. The communication challenge requires that clinicians make recommendations for patients whose perspective is at odds with the facts. Tailor plans in order to take account of the patient’s readiness to change.

Medical problems bring people with alcohol use disorders into frequent contact with clinicians. Effective intervention and referral for treatment requires clinicians to adopt evidence-based counseling strategies. In general, the strategies parallel those used in other behavior change situations, but interactions are always complex because of the intensely different perspective of clinician and patient. (3,13)

Proper counseling means creating a climate that is conducive to dialogue, responding to emotions, and adjusting conversations so that advice / recommendations are presented not only clearly but also consistent with patients’ readiness to change.

The following sections discuss the principles that underlie effective, compassionate front line counseling for patients in trouble with alcohol. The principles underlie all “brief interventions,” and apply whether the alcohol problems seem minor or severe. Some patients may need referral to a
**“Brief Intervention”**

“Brief intervention” is a specific term for 10-15 minutes of counseling, with feedback about drinking, personalized advice, and follow-up contact.

Brief interventions, as studied in a variety of practice settings, decrease alcohol intake and decrease the prevalence of at-risk drinking by about 10%. (4,6,12,17,19) In long term follow-up studies of up to 16 years, brief intervention decreased self-reported daily and binge drinking, as well as alcohol-related mortality. Clinician interviewing styles that are non-confrontational and aimed at enhancing patients' motivation are more effective at reducing (or stopping) drinking than confrontational counseling. Brief intervention can be effective whether patients are ready to take action to change, are thinking about change, or seem dead set against change at the time of the interview. (13,18)

Studies show that more than 75% of patients express some readiness to change and that readiness correlates positively with the severity of the drinking problem. These findings contradict the common belief that severe drinkers are precontemplative. In fact patients with less severe problems are less likely to be interested in changing and likely to benefit from concern-raising brief interventions(2,24).

---

**Advice, recommend**

In every interaction, make clear and definite recommendations. Then, negotiate specific goals and ways to achieve them. Express optimism. Avoid commanding or persuading, and do not force patients into “all or nothing” situations.

For patients with at-risk alcohol use, recommend a drinking goal that conforms to guidelines for safe use (NIAAA, above). For patients with alcohol abuse or dependence, recommend abstinence.

The "pathophysiology" section emphasizes the dynamics of denial. As preoccupation with alcohol progresses, many patients ignore reality, suppress negative feelings, and smoothly reject sound advice. For alcohol dependent patients, change seems unimaginable, like jumping into a featureless abyss. Specific attention to these dynamics improves adherence.

Give advice / recommendations with characteristics that are based on the extensive relevant literature (3,12,13,16):

- Base advice on expert opinion, facts and science, giving patients an objective rationale derived from a broader database than simply their case.

- Present recommendations explicitly, succinctly and clearly, even though experience shows that few patients will accept the advice.

- Stay in dialogue, listen to patients' perspectives and find common ground-explore options until patients choose an action that is a step in the right direction. If none can be found, agree to disagree, and continue the conversation at subsequent visits.

- Do not let "the best be the enemy of the good." A minimal action plan is to make a return visit, or perhaps to read a pamphlet from you, or keep a dairy or talk with a friend or spouse.

Advice / recommendation might sound like:
"Your weekend drinking is clearly above the safe limits that the NIAAA and other experts advise. I recommend that we try to work out a plan for you to cut back to safe limits" or,

"I recommend, based on data in the medical literature and my experience with experts who have advised me about similar patients, that you stop drinking all alcohol. Of course, no one can be certain that this will work for you." or,

"Most people find that talking with people in Alcoholics Anonymous is helpful. AA might or might not be right for you. I recommend you go there."

Next, ask patients what they think. Even when patients fail to agree to an action step, conversations that do not provoke more resistance and negativity often prepare them for an action decision at a later time.

Patients' reluctance and resistance often challenge clinicians' caring instincts. Clinicians may become hopeless and fail to use constructive skills and strategies. Then, mirroring their patients' unwillingness to face reality, they may decline to intervene, leaving patients' problems unaddressed.

Studies of successful interventions show that effective clinicians roll with resistance and remain consistently relationship-centered by responding with empathy to irritability and defensiveness. Principles of behavior change counseling (Modules 16, 24) and "Motivational Interviewing"(13) are applicable and helpful in their explication of strategies and associated skills. We illustrate these ideas in the following video, and discuss tactics for "being clear but not demanding" and for responding to reluctance with relationship-centered empathic statements in the pages that follow the video.

---

Create dialogue

Avoid monologue by alternating "asking" and "telling." As the encounter progresses, respond to resistance with reflection, and respond to agreement with "telling" more.

Employ a format of "ask, tell, ask."(Module 10) In this format, "ask" means to inquire about patients' ideas, reactions and feelings, and "tell" means to share facts and recommendations. Initially, ask for permission to discuss alcohol issues, then briefly "tell" (share) facts and advice, and then ask about patients' responses- this might include asking how they feel, what they think, or what they imagine to be next steps. Keeping "telling" brief helps clarity, and "asking" allows patients to choose "change enhancing" or "change obstructing" responses. Further, "asking" fosters exploration, choice and autonomy. The manner in which patients respond to inquiry about their perspectives on what clinicians "ask" or "tell" guides further counseling. Generally, "change enhancing" responses include statements of agreement, commitment or optimism; they suggest that further exploration of the data and options might be helpful.

Generally, "change obstructing" responses include disagreement, reservation, pessimism, defensiveness, non-committal statements, and questions that detour the dialogue; they suggest that clinicians should reflect back the "obstructing" response. Reflection invites patients to look inside themselves, encourages motivation and may build discrepancy between time present and an improved future.(3,13)

AnnotatedVideo (not shown in print-out text)

---

Focus on facts
Minimize defensiveness and argument by starting with facts, rather than conclusions, opinions or authoritative statements.

Create a climate of fact by giving information and recommendations in an objective or "scientific" way. Clinicians who in any way communicate, “I know what is right for you” provoke debate that is fruitless and a frustrating waste of time.

“Tell” patients the relevant data about alcohol problems in an impersonal way; such as the following:

"Research shows that treatment helps;"

"Having a high tolerance for alcohol means that a person is deprived of the early warning system that tells him to stop drinking before the alcohol level gets so high as to be dangerous;"

"95% of men drink less than 35 drinks per week;"

"Becoming sick in the morning until after a drink generally means a person's brain has become hooked on alcohol."

Create a dialogue and relationship by "ask"ing the patient what he thinks about the relevant facts. Patients also need to know about their own situation, and using numbers and "scores" (from rating scales, etc) encourages further discussion about the "scientific" and objective situation. Use language such as the following:

"Three of your liver tests are abnormal,"  
instead of "alcohol has damaged your liver;"

"Your alcohol level when you arrived in Emergency was .160,"  
instead of "You were drinking heavily before you came to Emergency;"

"You mentioned 3 important things, -- that your relationship with your wife is going poorly, that you are having stomach trouble, and that you lost your license to drive;"  
instead of "Alcohol is wrecking your marriage, your career, and your body."

Beyond “brief:” additional counseling

For patients with at-risk use, and others with mild alcohol abuse, many clinicians might wish to enhance office-based brief interventions with additional discussion and recommendations. Pharmaceuticals may be useful for withdrawal symptoms or craving.

Set aside 30-40 minutes for a longer visit. Ask the patient to invite a family member or friend to attend. Investigate the details about how drinking fits into daily life. Ask patients to list the positive and negative aspects of changing their alcohol use. This process produces a list of situations and triggers. Jointly problem-solve and develop specific methods to cope with these situations. Patients can write in a diary or notebook and review it daily as a reminder to practice using new strategies. Celebrate even small successes and reframe "failures" as learning opportunities. See patients weekly or at feasible short intervals for a time, to assure short-term success and tailor strategies. For patients whose progress is unclear or non-existent, make early referrals and frame the referral process in positive terms.

In addition to treating medical complications (examples: trauma, liver problems, infections),
Clinicians who make effective interventions adjust their tactics, but not the basic recommendation, to patients' readiness to listen, think and take action.

Because only the patient can effect change, the counseling task is to trigger change. Evidence shows that clinicians whose counseling aim is to build a sense of autonomy, optimism and confidence help trigger change. (3,12,13)

Most learners (and practicing clinicians) do not suggest ideas and conscientiously check them to see whether they can be adjusted to patients' level of resistance to change. When making suggestions, “ask” patients what they think about them. Importantly, do not present more facts to bolster the case for change, or try to persuade patients to adopt those suggestions. This strategy raises resistance and begins an enervating downward spiral that demoralizes patients and clinicians and assures poor adherence.

Below are example dialogues that highlight conversational adjustments for patients who seem 

- **Uninterested** in change, **uncertain** about change or **ready to take action**

- **Uninterested**: When a patient demonstrates little interest in changing, make a reflective statement that acknowledges this. Listen, and seek an action plan that suggests the patient take a closer look over time at the behavior and its ramifications. State that you are sufficiently concerned that you will bring it up again.

  "We clearly have different perspectives right now. I appreciate that you do not intend to quit drinking. I wonder if you would be willing to think more about what makes me so concerned before your next appointment?"

- **Uncertain**: Suppose a patient responds to inquiry and concern in a way that expresses uncertainty about changing (or outright ambivalence) such as the following:

  "Thanks for your concern, Doctor; you know me pretty well, so I suppose there is some truth in what you say,"

A “motivational” intervention that could be employed is to make a reflective statement and ask for more dialogue:

"I appreciate that you are thinking about this. Looking for your "some truth", would you be willing to review some good things about drinking as well as some not-so-good things for me?"

Continuing, emphasize autonomy and choice by saying,

"I’d value the chance to seek a deeper understanding of the total picture and help you make the best decision you can for yourself, as time goes by."

The general idea with patients not fully committed to quitting is to discern whether there is any action they might take, short of actually stopping drinking.

- **Ready for change**: Occasionally, patients will be ready to take action, and seek advice from a trusted source. Such a patient might say,

  "You know, a fellow at work has been pushing me to go to AA, and I almost went
with him after I got my DUI."

You might respond,

"It seems that we agree that it might be good to do something differently right now. Would you like to hear my advice? ... ...In fact, from a medical and health point of view, my recommendation is that you quit drinking. Many people learn a lot about themselves when they go to a few AA meetings with an open mind. Would you be able to quit and go to an AA meeting weekly until I see you again in a month or so?"

Augment patients' confidence about change by stating their special and unique strengths. Tell the patient why he has a chance of success, based on facts about his unique characteristics, past successes, attitude, and other attributes.

"You've told me how independent, even stubborn, you can be and that may mean that when you decide to do something difficult, you can stick to it."

Annotated Video (not shown in print-out text)

**Alcoholism treatment and follow up**

Clinician counseling is not “treatment” for severely affected patients. Specialized treatment and long-term programs support patients with mutual-help, daily care, intensive counseling, and extended stays in “half-way house” type facilities. Help patients follow through with referrals.

Recommend a mutual-help group for patients with alcohol abuse or dependence. Alcohol dependent patients may benefit from access to medical detoxification and multidisciplinary counseling opportunities. Severity of the drinking problem and consequences informs ultimate referral recommendations better than does the specific diagnosis of at-risk, abusive, or dependent use. Most people know about Alcoholics Anonymous (AA). Other mutual-help alternatives exist in many communities; two examples are Rational Recovery and Women for Sobriety, but their success rates are less clear than AA’s. Both inpatient and outpatient treatment programs help patients initiate and continue contact with community based self-help, halfway houses, and intensive counseling. Many communities support special needs programs, such as for adolescents, women, and patients with psychiatric problems.

Clinicians may choose to prescribe medication. Four are approved and effective, namely naltrexone, acamprosate, disulfiram, and extended-release injectable naltrexone. NIAAA guidelines (16, pps13-18) include valuable drug information as well as advice about improving adherence.

Confirm patients’ intention and commitment to follow through. Additionally, emphasize the need for support from specialist colleagues. Set up the appointment before patients leave the office. Assure patients that a referral letter will be sent. Let patients know that you will speak with the specialist and that you would like to participate in the treatment plan. As with all behavior change situations where patients do the work (no medical or surgical “cure” is available) results are uncertain, but evidence shows that counseling makes a difference.(14,16)

**CONCLUSION**

Interventions for patients with an alcohol use disorder, whether on the mild or severe end of the continuum of severity, can make a difference in health-related outcomes.
Recommendations should be clear, but the relationship-centered dialogue of intervention varies according to patients’ readiness to change.

Alcohol use disorders exist on a continuum, and clinicians in hospitals and offices frequently are patients’ initial contact with potential treatment. Clinicians should attend to any clues about an alcohol use disorder. Early intervention makes a difference in health-related outcomes, and there is no excuse for delay. In particular, both waiting to be certain exactly where a patient lies on the continuum and thinking the patient is uninterested in changing should not delay an intervention. Progress may seem slow or non-existent, but data show that persistence in making recommendations with relationship centered evidence-based behavior change counseling skills saves lives and diminishes suffering.

Working with patients with alcohol use disorders is sometimes discouraging and painful. Full scale treatment requires more resources than any one person can provide, so clinicians should recommend and foster patients' integration with networks of helpers like Alcoholics Anonymous and comprehensive treatment programs.

**BEHAVIOR CHECKLIST**

1. **Screening**
   - Follow up a positive “Prescreen” with either, “how many times in the past year have you drunk 5 or more drinks in a day (for men, or 4 for women or over 65),” or the **AUDIT** or **CAGE** test.

2. **Assessment / Diagnosis**
   - If screening is positive or any clue is present, ask about consequences and symptoms:
     - *Psychosocial symptoms* (relationship, job or legal problems, role failure, other drug use, depression, anxiety).
     - *Alcohol-specific consequences* (blackouts, arrests for DUI/OUI/DWI, AA attendance, family history).
     - *Alcohol-specific symptoms* (tolerance, withdrawal, difficulty with control or cutting down, preoccupation, continued use despite consequences).
     - *Somatic symptoms* (heartburn, trauma, insomnia).
   - Use reflections and empathic statements to respond to irritability, hostility, anxiety or defensiveness.
   - Refrain from responding to distracting questions.
   - Assess readiness to change.

3. **Advise / recommend**
   - Recommend abstinence for patients' with *alcohol abuse or dependence*.
   - Recommend a comprehensive treatment program, Alcoholics Anonymous, or other local facilities for patients with *alcohol abuse or dependence*.
   - Use "ask-tell-ask" strategy to present information and recommendations.
   - When offering information, feedback facts, not conclusions.
● Appreciate patient strengths; support self-efficacy, autonomy and choice.

● Use reflections and empathic statements to respond to reluctance, resistance and ambivalence about change.

● Arrange follow up.

REFERENCES


AUDIT-Alcohol Use Disorders Identification Test


1. How often do you have a drink containing alcohol?
   (0) Never (1) Monthly or less (2) Two to Four times a month 
   (3) Two to three times a week (4) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 to 9 
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly 
   (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly 
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly 
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative or a friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?
    (0) Now (2) Yes, but not in the last year (4) Yes, during the last year

Record sum of individual items scores here ________________.
("positive" = Total score of 8 or more = Alcohol Use Disorder present, see Ref. 10 for sensitivity and specificity of AUDIT and CAGE)

Table 1. CAGE screening for dependence symptoms.

1. Have you ever felt that you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)

Table 2. Symptoms of alcohol use disorders. (16-adapted)

If yes to one or more of the questions below, the patient has alcohol abuse. In either case, proceed to assess for dependence symptoms.

In the past 12 months, has patient’s drinking repeatedly caused or contributed to-
-risk of bodily harm (drinking and driving, operating machinery, swimming)
-relationship trouble (family or friends)
-role failure (interference with home, work, or school obligations)

If yes to three or more of the questions below, the patient has alcohol dependence.

In the past 12 months, has the patient-
-not been able to stick to drinking limits (repeatedly gone over them)
-not been able to cut down or stop (repeated failed attempts; may include abstinent periods)
-shown tolerance (needed to drink a lot more to get the same effect)
-shown signs of withdrawal (tremors, sweating, nausea, insomnia, if trying to quit / cut down)
-run-ins with the law (arrests or other legal problems)

-kept drinking despite problems (physical, e.g., blackouts, overdose, gastritis, liver trouble; psychological, e.g., anxiety, depression, request for psychotropic meds)

-spent a lot of time drinking (or anticipating or recovering from drinking)

-spent less time on other matters (activities that had been important or pleasurable)

"The Clinical Assessment of Substance Use Disorders"

Authors: Barbara A. Schindler, MD, and Ted Parran Jr., MD
Directed and produced by Christof J. Daetwyler, MD

This media-rich, on-line module was created through the collaborative efforts of the National Institute on Drug Abuse (NIDA), Drexel University College of Medicine, and the University of Pennsylvania School of Medicine as part of NIDA’s Centers of Excellence for Clinician Information.
This module was produced using Federal Government funds, therefore, the material is in the public domain and may be reproduced or copied without permission. Additionally, this curriculum will remain in the public domain even after publication on a copyrighted Web site.

A supplemental "Facilitator Guide" is available for download, as well as a QR barcode enhanced print version of this module.

Credits:

Author: Barbara A. Schindler, M.D, DFAPA, FAPM

Barbara A. Schindler, M.D., is the Vice Dean for Educational and Academic Affairs, the William Maul Measey Chair in Medical Education, and Professor of Psychiatry and Pediatrics, Drexel University College of Medicine. She founded and serves as the Medical Director of the Caring Together Program, an outpatient treatment program for women with addictive and psychiatric disorders.

Dr. Schindler is a graduate of Boston University and Women’s Medical College. She completed her training in adult psychiatry and child and adolescent psychiatry at Medical College of Pennsylvania. She is board certified by the American Board of Psychiatry and Neurology and has added qualifications in geriatric psychiatry. She served as Acting Chair of the Department of Psychiatry from 1993 to 1995. She has over 150 publications, abstracts, and presentations in consultation-liaison psychiatry/psychosomatic medicine, substance abuse in women, and medical education. She collaborated on a multi-centered study of the effects of financial stress on the physical and mental health of academic-health-center faculty.

Dr. Schindler has earned fellowship status in the American Psychiatric Association and the Academy of Psychosomatic Medicine and is a past-President of the Philadelphia Psychiatric Society. She served on the Council of the Academy of Psychosomatic Medicine and the Philadelphia Psychiatric Society. She is a member of Alpha Omega Alpha and is the recipient of the Commonwealth Board Award and the WMC/MCP Alumnae/i Association Service Award. She has been honored with the Association of American Medical Colleges Women in Medicine Silver Achievement Award, the Pennsylvania Psychiatric Society’s Presidential Award, and the Lindback Teaching Award.

Author: Ted Parran Jr, M.D. FACP, FAACH

Dr. Ted Parran is a 1974 graduate of Hawken School, a 1978 graduate with honors in Medieval History of Kenyon College, and a 1982 graduate of Case Western Reserve
University (CWRU) School of Medicine. He completed a residency in Internal Medicine at the Baltimore City Hospital of Johns Hopkins University School of Medicine. Dr. Parran was selected to be the Medical Chief Resident for 1 year following his residency, and he received the Outstanding Faculty Teacher Award from the Department of Medicine in 1987. In 1988, he returned to Cleveland and CWRU School of Medicine and is an Associate Clinical Professor of Internal Medicine. Dr. Parran pursues several areas of special interest in medical education including Dr.- Patient Communication, Faculty Development, Continuing Medical Education, and Addiction Medicine. In addition Dr. Parran is certified by the American Society of Addiction Medicine, and his group practice provides addiction and medical services to several substance abuse treatment programs and consulting services in northeast Ohio, including: the Cleveland VAMC, University Hospitals, St. Vincent Charity’s Rosary Hall, the Cleveland Treatment Center, the Salvation Army’s Harbor Light, GlenBeigh Recovery Services, Windsor, and the Huron Hospital detoxification unit. He is the co-director of the Foundations of Clinical Medicine Course for the first 2 years of the medical school curriculum, directs the Addiction Fellowships, and is the medical director of the Program in Continuing Medical Education, all at CWRU School of Medicine.

Content Expert: William D. Clark, M.D. FAACH

Dr. William Clark is an internist and addiction medicine specialist who retired from clinical work in 2004. Dr. Clark served as director of the internal medicine residency at the Cambridge Hospital, Medical Director of addictions programs in Massachusetts and Maine, and did alcoholism research during a sabbatical year in France. His publications include papers and chapters about clinician-patient relationship and communication, alcohol and drug problems and clinician self-awareness. He continues as a Lecturer in Medicine at Harvard Medical School, Boston, Massachusetts.

Dr. Clark is managing editor of DocCom. He is serving a 6-year term as a trustee (nonalcoholic) on the General Service Board of Alcoholics Anonymous. Bill is a founding member, Fellow, and President (2005) of the American Academy on Communication in Healthcare (AACH). Dr. Clark completed Circles of Trust facilitator training with Parker Palmer, Jr., Ph.D., and has brought elements of Palmer’s model into AACH’s clinician renewal courses.

Production Design, Production, Programming, and Implementation: Christof J. Daetwyler, M.D.

Dr. Christof Daetwyler is Associate Professor at Drexel University College of Medicine, Office of Educational Affairs. He spent most of his career on research, design, and implementation of technological enhancements in medical education. Before coming to Drexel University in 2004, Dr. Daetwyler served as Visiting Assistant Professor for 3 years at Dr. Joe Henderson’s Interactive Media Lab at Dartmouth College Medical School. There he produced and directed large-scale educational multimedia productions, among them "Smoking Cessation for Pregnancy and Beyond," which was funded by the Robert Wood Johnson Foundation. Dr. Daetwyler received his medical degrees from the University of Zurich Medical School in Zurich, Switzerland in 1993 and University of Berne, Switzerland in 1999. Dr. Daetwyler was the recipient of several prestigious awards, among them twice the European Academic Software Award (1998 and 2000) and the Surgeon General's Medal of Special Appreciation in 2004, received from the former Surgeon General of the United States, Dr. C. Everett Koop.

Communication Skills Expert: Dennis H. Novack, M.D.
Dr. Dennis H. Novack is Professor of Medicine and Associate Dean of Medical Education at Drexel University College of Medicine. He is a general internist who completed a 2-year fellowship with George Engel’s Medical-Psychiatric Liaison group in Rochester, N.Y. (1976-1978). Since 1978, Dr. Novack has been in academic medical centers, dedicated to improving education in clinician-patient communication and psychosocial aspects of care. First at the University of Virginia and then for 12 years at Brown University, he directed psychosocial education in primary care, internal medicine residency programs. He also co-directed the first-year medical student course in medical interviewing and psychosocial aspects of care at Brown University Medical School. At Drexel, he directs clinical skills teaching and assessment. He also directs the first-year course at Drexel on clinician-patient communication, psychosocial aspects of care, and clinician personal awareness and well-being.

Videographer: George Zeiset BA

George Zeiset received his diploma in the study of Radio, Television, and Film. He is the Director of the Technology in Medical Education (TIME) group, which is responsible for all aspects of technology and media for medical education at the Drexel University College of Medicine. In this function, he makes all lectures available online to the students. He is also responsible for setting up videoconferences and taping video for educational purposes.

Patients in the Videos: Robin George and Mike Ondri

Casting by Benita Brown. Robin George and Mike Ondri are longtime Standardized Patients at Drexel University College of Medicine.

Version History:

- Version 3.0.0 as of 10/14/2011 - HTML5 version implemented - iPod fully supported
- Version 2.1.0 as of 10/30/2009 - final edits before opening to the public incorporated
- Version 2.0.2 as of 10/05/2009 - Complete revised version with 5 real patient interviews
- Version 2.0.1 as of 09/23/2009
- Version 2.0.0 as of 07/22/2009
- Version 1.1.1 as of 06/24/2009 - Questions for reflection; fields added to fill in answers
- Version 1.1.0 as of 03/03/2009
- Version 1.0.0 as of 01/06/2009

VIDEO (not shown in print-out text)

Rationale

by Barbara A. Schindler, M.D.
Questions for Reflection:

1. How have your experiences with patients, family members, friends, and colleagues with substance use disorders affected your attitudes towards substance-using patients?

2. What reservations do you have about accepting the disease model for substance use disorders?

3. Why do clinicians often fail to ask substance use screening questions?

4. Describe how you feel when your patients fail to curb their substance use!

5. What are the implications of threatening communications to patients, eg. “You will die if you do not stop using drugs!”

6. How do you respond to some patients’ disrespectful, dismissive, irritated, or angry responses when asked about substance use? What behaviors are most likely to “push your buttons,” so that your responses are not therapeutic?

7. How would you respond when patients you respect and know well request prescriptions for controlled drugs that are not of clear medical value for them—e.g., diazepam, or oxycodone for chronic back pain or headache, or additional sedatives for insomnia?

When you're done, please enter your name in the field below and click the "DONE" button.
Name: [Field for name input]  DONE
**Key Principles:**

1. In 2008, an estimated 20.1 million Americans aged 12 or older were current (past-month) illicit drug users. (8.0% of the population). (2008 SAMSHA National Survey on Drug Use and Health report [http://www.drugabusestatistics.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#Ch2](http://www.drugabusestatistics.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm#Ch2), figure 2.2)

2. Substance use disorders affect 45% of patients who present for medical care but are routinely unrecognized by healthcare providers. (1)

3. Clinicians and other healthcare providers can play a key role in facilitating the diagnosis and treatment of patients with substance use disorders.

4. Conducting an unbiased clinical interview is critical in making an accurate diagnosis and facilitating treatment of patients with substance use disorders.

5. The use of structured screening and assessment strategies (e.g. CAGE Questionnaire) is essential in the assessment of substance use disorders.

6. Staging the severity of addiction, calibrating patients’ readiness to change behaviors, and willingness to access professional help are crucial to good medical care.

7. Patients are more likely to follow plans that are negotiated in partnership with clinicians and renegotiated at follow-up visits.

8. Sustained recovery requires many resources. To achieve treatment goals, clinicians should become comfortable referring patients to resources such as self-help groups, professional treatment programs, and psychiatrists to treat co-morbid psychiatric disorders.

**Learning Goals:**

At completion of this module, you will be able to:

1. Describe the essential components of the medical model of substance use disorders.

2. Delineate the interviewing skills necessary to screen effectively for substance use and abuse.

3. Understand the high rate of psychiatric and medical co-morbidity and more effectively screen patients for these disorders.

4. Demonstrate skills for evaluating patients’ stage of change, readiness to accept the diagnosis, and readiness to undertake behavior change.

5. Clearly and supportively recommend treatment to patients with substance use disorders.

6. Describe the skills required for addiction prevention counseling.

7. Define the skills that help set respectful limits on patient requests for prescription medication.

9. Demonstrate knowledge of substance use disorder treatment standards and the ability to recommend appropriate referrals.

INTRODUCTION

Substance abuse and substance dependence are commonly seen in patients in medical practices, and are frequently co-morbid with other medical and psychiatric disorders. Considerable societal stigma exists toward patients with substance use disorders; healthcare providers frequently have negative attitudes toward these patients as well. Fortunately, there are established communication skills you can master that will facilitate the establishment of therapeutic relationships and motivate patients for treatment.

Substance abuse and substance dependence have a 10.3% lifetime prevalence; yet, they are routinely underdiagnosed by healthcare providers. (2, 3) Approximately 20.1 million Americans age 12 and older used illicit drugs in the past month (8.0% of the population). (4) The prevalence of illicit drug use is 7 to 20% in ambulatory practices and up to 50% in trauma patients. (1) Psychiatric and physical co-morbidities are very common, and 60% or more of patients with substance use or dependence suffer from an additional psychiatric disorder.(4,5) In 2008, an estimated 23.1 million persons age 12 or older needed treatment for an illicit drug or alcohol use problem (9.2% of the population over 12). Of these, 2.3 million (0.9% of the population and 9.9% of those who needed treatment and received it) received treatment at a specialty facility.(4) In addition to the health and social consequences, these high rates of use and of undertreated patients contribute to the staggering financial costs of substance use (illicit drugs and alcohol), which are estimated at $416 billion per year. These costs, do not, however, translate into treatment costs. For example, in 2003, only 1.3% ($21 billion) of total health care expenditures were for the treatment of alcohol and drug disorders.(6,7)

People with substance use disorders are heavily stigmatized. Clinicians are not immune from negative attitudes about substance use disorders. The identification, assessment and referral for treatment of patients are strongly influenced by clinician attitudes and life experiences with personal, family, or prior patients’ substance use. Effective tools and strategies can help you recognize the physiologic and behavioral red flags of addiction and elicit a substance use history in a nonjudgmental manner, so you can make the appropriate diagnosis and develop a patient-specific plan for treatment and referral. (8)

This educational module on the clinical assessment of substance abuse disorders presents written text and instructional videos that provide the knowledge, skills, and attitudes needed in the screening, evaluation, and referral of patients with substance use disorders. The video examples in this module focus on prescription drug abuse, a common and increasing problem in clinical practice. However, the strategies for screening and referral that we present are the same for all substance use disorders.

For additional information on drug abuse and addictive disorders, please go to the National Institute on Drug Abuse’s NIDAMED Web site: http://www.drugabuse.gov/nidamed/

MEDICAL MODEL OF SUBSTANCE ABUSE AND SUBSTANCE DEPENDENCE

Substance use disorders are complex chronic, relapsing and remitting diseases in both
presentation and pathogenesis, resulting in significant morbidity and mortality. Despite the neurochemical changes and the chronic and relapsing nature of these diseases, treatment is effective and recovery possible.  http://www.drugabuse.gov/scienceofaddiction

- Substance use disorders are characterized by compulsive drug seeking and use despite harmful physical, psychiatric, and interpersonal consequences. (9,10)

- Substances of abuse alter brain function, impact many health conditions, and can lead to major public health problems, including the transmission of HIV, hepatitis, and tuberculosis.

- Steady use of psychoactive substances causes biochemical and structural changes in the brain that limit self control and result in substance abuse and dependence as defined in the DSM IV-TR (see text under the heading “Diagnostic Criteria,” below). Substances of abuse acutely activate and chronically dysregulate brain reward functions, largely via mesolimbic dopamine pathways. Brain-imaging studies show changes in both anatomy and physiology in areas known to be critical for judgment, decision making, learning, memory, and behavior control. (11) See also http://www.drugabuse.gov/pubs/teaching/Teaching6/Teaching.html.

- “Addiction” is a commonly used but frequently nonspecific term. In this text, “addiction” is defined as a chronic, relapsing brain disease, characterized by compulsive drug seeking and use despite known harmful consequences. It may include physical dependence, which refers to brain changes associated with daily substance use that produce noxious symptoms (e.g., gooseflesh, runny nose, hyper-alertness, sweating, tremor, confusion) when the person stops using (i.e., withdraws). Withdrawal is a powerful stimulus to use again, and the symptoms abate when use is restarted. However, physical dependence is not the same as addiction.

- Substance use disorders have a multi-factorial etiology, including genetics (can account for 40–60%), biologic changes in brain function, and pre-existing co-morbid Axis I psychiatric disorders. Family history, societal, and life events can also be important etiologic factors. However, most people who "experiment" with drugs or alcohol do not develop a substance use disorder.

- Substance use disorders are a major co-factor in societal violence.

- Substance use often begins in childhood or adolescence, when the brain continues to undergo dramatic changes. One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control—putting adolescents at increased risk for poor decisions (such as trying drugs or continued abuse). Moreover, the immature brain may be particularly vulnerable to chemical changes caused by psychoactive drugs, and therefore drug use may increase the risk of abuse or dependence in adolescents and young adults. Adolescents who use alcohol or other psychoactive drugs also frequently
have academic and social problems, as well as encounters with the criminal justice system.

- Symptoms of substance abuse, dependence, and withdrawal can mimic symptoms of major psychiatric disorders.
- Treatment works! Treatment enables people to regain control of their lives and counteract the powerful disruptive effects on the brain and behavior of substance abuse or dependence.
- Relapse rates for treatment of substance use disorders are similar to those of other chronic illnesses, like asthma or diabetes. Thus, substance use disorders should be treated like any chronic illness, with relapse serving as a trigger for renewed intervention.

### Diagnostic Criteria

To serve your patients well, you must know features that distinguish the substance use disorders from one another and from non-problem-use. More important, you must take action when you are concerned, even if you cannot make a definitive diagnosis.

The DSM IV criteria for distinguishing substance use disorders, including substance abuse, dependence, and substance-induced disorders, are delineated in the next sections. The symptoms that practicing clinicians witness are frequently only the tip of the iceberg. Any concern on your part may indicate a more serious problem. Therefore, take action as soon as your screening protocols or the presence of any “red flag” suggests substance use problems. Refer all patients with evidence of a substance use disorder for further evaluation and possible treatment by a substance abuse professional.

Substance abuse specialists have the time and tools to make an exhaustive diagnostic inquiry; to distinguish between substance use, abuse, and dependence; and to adjust their interventions accordingly.

### Substance Use Disorders and Substance Related Disorders

The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR (12), categorizes Substance Use Disorders and Substance-Induced Disorders, and specifies criteria for diagnosis: **Abuse and dependence are maladaptive patterns of substance use leading to clinically significant impairment or distress, as manifested by persistent or recurrent social or interpersonal problems caused by substance use.**

The Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, categorizes Substance Use Disorders and Substance-Related Disorders as follows:

#### 1) Substance Use Disorders include:

- **Substance Abuse:** Maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following social or interpersonal problems caused by use of substance, within a 12 month period:
  - Recurrent substance use resulting in failure to fulfill major role obligations at work, school or home.
  - Recurrent substance use in situations in which it is physically hazardous
  - Recurrent substance related legal problems.
Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

**Substance Dependence:** Maladaptive pattern of substance use leading to impairment as manifested by three or more of the following in any 12 month period of time:
- Tolerance- either 1) marked need to increase amounts of substance to achieve intoxication or desired effect or 2) markedly diminished effect with continued use of the same amount of substance
- Withdrawal- either 1) characteristic withdrawal symptoms of a specific substance or 2) use of the same or similar substance to avoid withdrawal symptoms
- Substance taken in a larger amounts or over a longer period of time than was intended
- Persistent desire or unsuccessful effort to cut down or control use
- Excessive time is spent in activities necessary to obtain the substance or recover from its effects
- Important social, occupational or recreational activities are given up or reduced
- Substance use continues despite knowledge of having persistent physical and/or psychological problems caused by the substance

**2) Substance-Related Disorders** include, but are not limited to:
- Intoxication
- Withdrawal
- Delirium and dementia
- Amnestic disorder
- Psychotic disorder
- Mood disorder
- Anxiety disorder
- Sexual dysfunction
- Sleep disorder

**SCREENING FOR SUBSTANCE USE DISORDERS**

A good clinical interview includes questions about substance use and sequelae of use across medical, psychiatric, personal, legal and social domains. Pay close attention to high risk or under recognized patients including pregnant women, young and older adolescents, older adults, Native Americans, health care providers, noncompliant patients, those with major psychiatric disorders and individuals in the criminal justice system.

- Screen all new patients and reevaluate established patients periodically. Data show that clinicians very often overlook substance use disorders. In one primary care study, clinicians reported a prevalence of substance abuse disorders of less than 1% of their patients despite an estimated substance abuse prevalence of 2%-9%.(3)

- Place particular attention on high risk patients with co-morbid medical or psychiatric disorders, including those with chronic pain, gastrointestinal complaints (abdominal pain), systemic infections including Hepatitis B and C, HIV/AIDS, other STD’s, bacterial endocarditis, pulmonary disease, obesity, cardiovascular and cerebral vascular disease, trauma including motor vehicle accidents, gunshot wounds, and psychiatric symptoms including depression, anxiety, and insomnia. (13) (see [http://www.drugabuse.gov/consequences](http://www.drugabuse.gov/consequences))
The assessment and management of chronic pain presents complex challenges to the clinician. Some patients will come to clinicians having been treated with narcotics, and feel they cannot function without them. It is important to remember that pain is a subjective sensation that is very real for the patient. Many factors influence the processing of pain signals and the sensation of pain, including past life experiences, personality traits, fear and anxiety, the meaning of the pain, depression, “secondary gains,” etc., in addition to any pathology that may be present. The factors that contribute to a patient’s perception of pain may need to be evaluated over several visits, sometimes with the help of a pain professional or psychiatrist. All patients with chronic narcotic use for painful conditions should be evaluated for substance use and abuse disorders.

If any of the known medical, psychiatric, familial, social, school or employment, and legal “red flags” are present (See next section on “Red Flags.”), a more detailed evaluation is needed to ascertain the presence of a substance use disorder and the patient’s readiness to accept treatment.

When screening for substance use disorders, include questions about both alcohol and drug use, which are frequently linked. Many patients use more than one substance of abuse. Each should be explored. Ask specifically about tobacco (cigarettes, cigars, smokeless tobacco), alcohol (beer, wine, liquor), marijuana, cocaine/crack, methamphetamines, other stimulants, opioids (heroin and prescription pain medications), PCP, inhalants, and other prescription "pills." (8,14,15,16)

For example, the NIDA Modified Alcohol, Smoking, and Substance Involvement Screening Test (NMASSIST) provides screening questions covering all drugs of abuse (specifically separating out prescription drugs from similar street drugs).
http://www.drugabuse.gov/nidamed/screening

Please click the video-button on the left to play Dr. Parran’s Comment on screening.

Studies show that “subtle” screening is not better than direct questioning. (16) Specific screening strategies include simple structured questionnaires, such as the CAGE-AID, adapted from the widely used CAGE questions for alcohol dependence. (17,18)

With adult patients, start with a question about use: “Do you use, or have you ever experimented with alcohol or other substances?”

If “yes”, or if the answer is equivocal, follow with:

- Have you ever felt a need to Cut Down on or Control your use of alcohol or other drugs?
- Have friends/family made comments to you about your use of alcohol or other drugs … have those comments ever Annoyed you?
- Have you ever felt bashful, embarrassed or Guilty about things you have said/done when using alcohol or other drugs that you would not have said/done otherwise?
- Do you ever use Eye-openers (drinking or using in the morning to “get going” or settle your nerves)?
Please click the video-button on the left to play [Dr. Parran’s Comment](#) on patients’ positive responses to these questions.

- If any answer is positive, initiate a “Brief Intervention” (below), but before doing so, ask follow up questions, because the patient’s responses to them will help you structure the particulars of your brief intervention conversation.

- Define patterns of use for each substance including the quantity, duration of use, frequency of use during that time, route of administration, effect of use, strategies used to acquire substances and cost. Explore periods of abstinence and triggers to use substances along with associated physical symptoms. (18)

One helpful strategy is to ask the patient about his/her perspectives and observations about their use and consequences. Helpful questions include the following:

- *Do you ever think you use too much?*
- *Have you ever tried to cut down on your use?*
- *Have you needed to use more to get the same effect?*
- *Has use created any problems, e.g. medical, educational, job?*

---

**Red Flags for Substance Use Disorders**

Despite good interview skills and use of effective screening tools, many patients with serious substance use disorders escape identification in clinicians’ offices. Attending to behavioral and physical **red flags** will help you identify a significant subset of patients who would otherwise remain “under the radar,” and thus not benefit from intervention.

Patients with substance use disorders are often reluctant to reveal them. They may fear negative judgments, be embarrassed about their inability to control their lives, or be in denial about the extent of their problems. In a variety of subtle or not-so-subtle ways, patients effectively avoid disclosure. Their methods include not listening to questions; minimizing use or consequences of use; changing the topic; showing irritation, anxiety, or other symptoms that discourage further inquiry; blocking many facts from their own consciousness; and outright lying

Please click the video buttons on the left to see what Reno and Rhonda have to say about interactions with their doctors.

However, there may be signals that appear in an interview, during the physical exam, in prior records or in statements from significant others, office staff, or hospital staff, that raise concern about a patient’s substance use. These “red flags,” whether mentioned by the patient, family, or another information source, should be an indication to follow up with the same diligence and persistence as you would after a positive drug screen or disclosure of heavy substance use, in order to ascertain the presence of a substance use disorder and the patient’s readiness to accept treatment.
Some common “red flags” are in the bulleted list below.

- **Physical findings**: Alcohol on the breath, ascites, an enlarged liver, nasal ulcers or a perforated septum, excoriated skin (from scratching), track marks, skin abscesses, obesity or anorexia, abnormal gait, tremor, slurred speech, change in pupil size, injuries, chronic pain, blackouts, accidental overdoses, withdrawal symptoms, other liver or gastrointestinal problems, premature labor, and vague somatic complaints.

- **Mental symptoms**: Depression, anxiety, flashbacks, insomnia, suicidal behavior, paranoia, irritability, vagueness, hallucinations, memory and concentration problems, and defensiveness about questions relating to substance use.

- **Social Problems**: Isolation/withdrawal, loss of previous friendships, marital difficulty including domestic violence, and loss of interest in prior activities (e.g., sports, hobbies).

- **Education and employment history**: School failure or poor grades, job losses, and frequent job changes.

- **Legal problems**: DUI, assaultive or violent behaviors, stealing, drug possession, and prostitution.

- **Family history**: May be positive for substance use or mental disorders; developmental problems in children.

## Clinician Attitudes

All patients have the same human needs for feeling well, attachment to others, and sense of self-control. Clinicians who have had difficult experiences with patients or others with addictive disorders may expect patients who have a substance use disorder to betray their trust and to manipulate them with drug-seeking behavior. These early experiences can lead to persistent negative attitudes, including cynicism and hopelessness resulting in lack of empathy and poor or inadequate screening for substance use disorders. These negative clinician–patient interactions can also adversely impact patients’ willingness to discuss use and accept referrals for treatment. (17)

You can enhance your care of patients with substance use disorders by reflecting on your own attitudes and discussing them with colleagues, by increasing your knowledge about the medical nature of the disease and the effects of substance use disorders on patients’ lives, and by practicing discussions about diagnosis and treatment with patients who are fearful and discouraged.

- Significant societal stigma still exists toward patients with substance use disorders despite significant advances in scientific knowledge, diagnosis, and treatment. (9,18)

- Remember that addiction is a disease of the brain and comparable to other chronic medical conditions such as diabetes, asthma, or hypertension, which also need ongoing monitoring and treatment.

- Lack of knowledge about clinical screening techniques and referral resources, however, increases clinician reluctance to evaluate patients for substance use disorders.
Anger toward patients, especially when they are noncompliant or relapsing, will only drive a wedge between the patient and clinician and exacerbate noncompliance.

Negative clinician attitudes can be manifested in the way clinicians ask and respond to questions about substance use, e.g., “You don’t use drugs, do you?” or in responding “Good” when a patient initially denies use.

Addressing patients’ drug-seeking behaviors respectfully and directly, in an empathic manner, while setting appropriate limits on requests for prescription drugs, will increase the possibility of engaging patients in treatment.

Patients’ behaviors may continue to be frustrating, but a positive attitude and belief in the possibility of recovery can energize patients. After all, many patients do recover, though it may be a long process and take several interventions. You can visualize frustrations as challenges to overcome, and feel compassion for patients’ struggles. Learning and using effective communication strategies and setting relationship limits in a respectful and straightforward manner create a healing relationship. Your hope and respect give your patients both hope and a new measure of dignity. If patients feel that you won’t give up on them, they may be less likely to give up on themselves.

Respond to irritability and suspicion with interventions that reflect what you hear

- "Many people are concerned about these questions." or
- "I hear some concern or irritation in your voice."
- "I’m feeling a bit confused by your responses. Help me better understand what you are saying."

When patients express irritation with your reflections or your limit-setting, or at their own shortcomings, here are some helpful responses for you to consider.

- "I hear your frustration that I will not prescribe more oxycodone for you” or
- "I understand your frustration. Patients in recovery tell me that my firm limits were helpful in getting them into treatment; I hope that will be the case for you.”
- "I hear your sense of hopelessness now, and I’ve heard so many people turn that around when they get into treatment.”
- "I know you feel bad about failing to carry out the plan. But let’s look at some of the details together and see if we can learn something that will help you succeed the next time."

---

**Physical Examination**

Prognosis for recovery is better if diagnosis and intervention are made early in the course of the disease. Some physical findings may be present in early stages of substance use disorders. Others, particularly the "classic" physical findings occur only in later stages.
Injuries from accidents, or from altercations in the home or on the streets, may appear early in the course of substance use disorders, and they are always cause for active intervention.

Other early clues include alcohol on the breath; signs of intoxication such as abnormal gait, slurred speech, sedation, dilated or constricted pupils, excoriated skin (from scratching), track marks, and skin abscesses; and behavioral symptoms such as irritability, vagueness, paranoia, and poor concentration.

The earlier a diagnosis is made, the better the prognosis. However, use over periods of years produces physical findings that make diagnosis much easier. Some examples of physical symptoms and findings that ensue after persistent use include the following:

- Malnutrition, including cachexia, but also obesity
- Systemic infections including cellulitis, sexually-transmitted diseases, HIV, hepatitis B and C, tuberculosis, and bacterial endocarditis
- Elevated blood pressure, tachycardia, chest pain, transient ischemic attacks, restlessness, sweating, and tremor—from withdrawal
- Physical damage from administering a drug that involve chronic sinus/nasal problems, worsening bronchitis from marijuana or cocaine smoking, or "track marks" from injection drug use
- The myriad systemic effects of alcoholism, including delirium, liver enlargement or failure, ascites, anemia, thrombocytopenia and bleeding, seizures, trauma, myopathy, and cardiomyopathy
- In pregnant women, abruptio placenta, premature birth, low gestational size, and neonatal withdrawal syndrome

Intervention may seem more difficult in later stages of the disease process, but many patients have suffered enough by that time and are more ready to accept the diagnosis and referral for treatment with experienced professionals. Be clear about availability and efficacy of treatment, even after many years of destructive use; be respectful and compassionate; and be persistent with later-stage patients.

For more information about specific medical consequences of substance use, please see [http://www.nida.nih.gov/consequences/](http://www.nida.nih.gov/consequences/)

**Laboratory Evaluation**

Lab testing has limited usefulness in the diagnosis of substance use disorders and in the discovery of associated physical harm. Drug testing does not measure severity of the disease. However, testing to monitor drug use is an important component of every treatment regimen.

- No specific laboratory test establishes an unequivocal diagnosis of substance use disorder; however, blood alcohol levels may confirm tolerance, or detection of another drug may confirm the origin of coma or confusion.
- Routine laboratory screening including liver function tests, complete blood count (anemia from chronic gastritis or a slightly high Mean Corpuscular Volume [MCV] with excessive alcohol consumption), and vitamin B12 and folate levels occasionally are the "red flags" that stimulate further diagnostic inquiry.
Blood alcohol levels, breathalyzer test results, urine drug screens, and, less commonly, hair and saliva analysis can be used to assess patients for possible alcohol and other drug use. A drug screen may be useful in evaluating an adolescent with school problems, or in accidents, domestic violence, or other trauma situations.

Performing urine and blood screens in some situations (e.g., school, employment) may be controversial, so it is advisable to obtain the patient’s (and/or parents’) permission before initiating such screens. Failure to do so can damage the clinician-patient relationship and cause legal consequences for the clinician.

Blood, urine, and saliva studies add a crucially important dimension to the effectiveness of treatment programs. Testing adds structure and limits that are critical aspects of helping patients regain self-control and self-respect.

Annotated Video (not shown in print-out text)

THE BRIEF INTERVENTION

When clinical screening indicates a potential substance use disorder, assess the patient’s readiness to change and conduct a brief intervention to facilitate treatment engagement.

Take steps to determine the patient’s willingness to accept the diagnosis and accept further exploration, intervention, and referral for treatment. Prior to discussing treatment options, check patients’ readiness to change their behavior. Inquire directly about patients' interest in changing and about their confidence in accomplishing change.

In a brief intervention, you tell the patient your diagnosis and specific recommendations in a matter-of-fact and non-confrontational way. You offer educational materials and choices about next steps, emphasize that any change is up to the patient, and convey confidence in the patient's ability to change his or her behaviors. You help the patient work out appropriate and doable next steps toward accomplishing your recommendations. Encourage the patient to regularly report progress toward his or her established goals. (18)

You then make definite treatment recommendations, tailoring your conversation based on the patient's apparent readiness to take action. Acknowledge that the patient is the one who decides what to do and, in fact, does all the real work.

Most clinicians find that telling patients of a diagnosis of addiction is a difficult task, an uncomfortable example of "giving bad news." The discomfort can arise from an incomplete understanding of the pathophysiology of substance use disorders, from previous negative experiences with substance abusing patients, from negative judgments about the patient's behaviors (impulsivity or criminal activity), and from a lack of practice with skills for this special type of doctor-patient interaction. The following guidelines present ideas about the content of recommendations, the process of giving them, and some "how to's" about skills for responding to patients' reactions, as well as information that may assist you in examining your own biases.

Content of a Brief Intervention

This section delineates the principles and rationale for a brief intervention, along with sample dialogue for handling patients' denial and their normal resistance to changing their behavior that has progressed to the point that it controls their lives. Depending on severity, you will support positive lifestyle choices, recommend abstinence from illicit drug use, recommend that
psychoactive prescription drugs be taken only as prescribed, and suggest referral to professional treatment.

All intervention dialogue with patients should be
- direct
- empathic
- nonjudgmental

When talking about next steps, present information without alienating patients who may be ashamed, in denial, ambivalent, or resistant to change. The use of shame, guilt, threats, confrontation, arguments, and arbitrary treatment plans is counterproductive and should be avoided. Express optimism about recovery and willingness to continue to work collaboratively with your patients. (18)


**Non-problem use:**
For patients who are using substances but appear to be at low risk of a substance use disorder, give them information about safe limits for alcohol use, and acknowledge that the only reasonable advice about other drug use is not to use illicit substances and not to exceed amounts prescribed for any psychoactive prescription drugs. Continue to screen patients periodically to verify that they have not developed a substance use disorder.

**Substance use disorders:**
Explicitly and clearly recommend that patients with substance abuse or dependence abstain from all illicit drugs. For patients with a co-morbid psychiatric disorder, help the patient find a qualified psychiatrist to prescribe and supervise the taking of any appropriate psychoactive drugs—it is particularly helpful if the psychiatrist is associated with a substance use disorder treatment program. Coordination of care is essential. Do not prescribe any psychoactive drugs for patients, unless they are active in a treatment program, and then only with specific guidance from that program; otherwise your prescriptions may not be effective, and they are likely to worsen patients’ problems. Articulate your medical concerns and be specific about the patient’s substance use and the related medical issues. Provide patients with written information from the National Institute on Drug Abuse (NIDA) about drug abuse disorders and steps they can take. It is important to convey that you believe they need the help of substance abuse professionals and that you would like to refer them to local treatment programs.

**Substance dependence:**
Recommendations for patients who have progressed to dependence are essentially the same as for substance abuse—abstinence and participation in local treatment programs. Office counseling is rarely useful for patients who are not participating in other treatment activities and it unwittingly contributes to prolonging or worsening the dependent state. You may wish to follow up and support such patients, but leave the treatment to professionals.

Under normal clinical situations, you should not prescribe medications that drug-dependent patients can abuse. Instead of prescribing, respectfully and calmly say "no" and continue recommending that the patient take advantage of specialist treatment. No matter how persuasive (or demanding) patients are, or how much you think a small dose of “x” might ease their suffering, we cannot emphasize enough this caveat. **Patients who are drug dependent and require narcotic medication for pain management following surgery or trauma should be managed collaboratively, by their surgeon/trauma clinician, dentist, and addiction treatment professional. The patient always needs to be an integral part of the treatment team.**
Determining Readiness to Change

When clinical screening indicates a potential substance use disorder, take steps to determine the patient’s willingness to accept the diagnosis and accept further exploration, intervention and referral for treatment. Prior to discussing treatment options, check patients’ readiness to change their behavior. Inquire directly about patients’ interest in changing, and about their confidence in accomplishing change.

Researchers have found that patients go through a series of predictable stages in the process of changing unhealthy behaviors. Stages of change include: precontemplation, contemplation, preparation, action, and maintenance. (20) It is important to understand what stage your patient is in, since your counseling will need to address the patient's particular needs and expectations relevant to that stage. Briefly, in Precontemplation, the patient is content with the behavior and doesn't see the need to change. In Contemplation, the patient understands that there are benefits of the behavior, but also risks and current negative consequences, and is thinking about changing the behavior. In Preparation, the patient has decided that it is best to change the behavior, begins to gather information on what it will take to change, and plans concrete actions necessary to change. In Action, the patient undertakes the necessary behavior, social, and environmental changes necessary. In Maintenance, the patient practices the many behaviors necessary to substitute for the previous unhealthy behaviors and to avoid restarting the previous behaviors. In Relapse, the patient restarts the previous unhealthy behaviors and usually returns to the contemplation stage.

Please click the buttons "Contemplation", "Action", and "Relapse" in the graphic on the left to play video examples showing interviews of Ms. Anderson in these stages. Below are videos of actual patients illustrating maintainance.

Asking two questions about patients' conviction and confidence helps you ascertain their motivational readiness. Conviction assesses what patients believe about the importance of taking action, and confidence assesses what patients believe about their present ability to adopt or change a behavior (despite obstacles or barriers.) The latter is often referred to as their degree of
"self-efficacy."

Ask patients to help you understand where they stand by using a numerical rating scale.

"On a scale of 0–10, how convinced are you that quitting cocaine is important?"

Not only will patients' answers to readiness questions alert you to material not usually made explicit, but also many patients respond with more dialogue and useful information about the past and the present. This is true even when patients protest that they do not like to use number scales.

Usually, asking why the number the patient chose is not LOWER than the one the patient named proves a helpful continuation of the dialogue. You may wish to incorporate this tactic in your Brief Intervention (below), perhaps saying,

"So you are at a "6" about thinking you need to quit cocaine; I'm wondering why you did not name a lower score?"

Asking about lower scores encourages patients to speak (and to hear themselves speak) about change in positive terms. You can then move more smoothly to talking about next steps.

Frame your confidence question as follows:

"Let's suppose for a moment that you were a 10, completely convinced that you should cut down or quit; on a 0–10 scale, how confident are you that you would be able to entirely abstain for the next 4 weeks?"

If the patient chooses a low number, you might ask, "What would it take for you to get your confidence level higher, say to an 8?" The patient may then suggest strategies that develop a greater sense of self-efficacy and hope.

---

**The narcotic contract**

When patients come to you who are already taking narcotics for chronic pain, it may be unclear that substance abuse is a significant problem. For these patients, it is helpful to be explicit about the circumstances under which you will prescribe narcotics. Asking your patient to sign a narcotic contract can be very helpful.


In the video on the next page, you can observe Dr. Parran discussing a narcotic contract with a patient.

---

**Dealing with Resistant Patient Behaviors**

Behavior change is difficult for everyone. Patients’ resistance to accepting a substance use diagnosis or treatment is frustrating and often contributes to clinicians’ negative counter-transference behavior and defensiveness. Talking with patients who do not appear to want help enervates clinicians.
In dialogue with a respectful clinician, some patients are prepared to accept their diagnosis and a treatment referral. On the other hand, many do not initially. Clinicians who seek to understand patients’ resistance to change can develop an effective treatment alliance. During ongoing conversations they can use their understanding of the nature of resistance to augment patients’ intrinsic motivation and hopefulness and shepherd patients towards recovery.

- Patients suffering from the disease of substance abuse or dependence are ensnared in diverse traps that lead to emotional isolation, irrational fears, discouragement, and hopelessness, accompanied by an overwhelming inner certainty that they are worthless and undeserving persons. Some of these traps include the following:
  - Estrangement from family
  - Loss of friends who are not part of a substance-using subculture
  - Daily life restricted to obtaining the substance, or to finding the means to obtain it
  - Large amounts of time recovering from the effects of use
  - Criminal behaviors such as shoplifting, burglary or other types of stealing
  - Daily small and large lies about feelings and about actions
  - Negative interactions with healthcare personnel, particularly around episodes of intoxication or injury
  - Begging, pleading, or wheedling for their substance of choice, or any substitute that might stem the urge or craving—from doctors, pharmacists, dealers, and other users
  - Destructive episodes of uncontained anger or impulsivity, resulting in violence to friends, family, or strangers such as pedestrians, people in other vehicles, or healthcare personnel
  - Repetitively and abjectly poor performance of social roles such as parent, spouse or partner, worker, or citizen

- The psychological mechanism of denial, intrinsic to the disease process, may play a key role in the patient’s inability to recognize the problem and seek treatment. Sporadic or binge users of psychoactive drugs can have even more difficulty saying, "I can stop anytime."

- Shame and guilt based on reactions from friends and family contribute to resistance. When patients imagine their clinicians’ negative response to discovering their involvement with substance use, their shame and guilt and need to stay hidden increase further.

- A co-morbid psychiatric disorder can limit patients’ ability to accept a diagnosis or participate in treatment.

- Substance use-induced cognitive impairment can impede patients’ understanding of the need for treatment and ability to follow through with treatment.

- In concert with the patient and his or her family, develop a differential diagnosis as to why a patient is resistant to treatment. Remain open to addressing the patient's concerns and resistances without confrontation, and develop skills and strategies that effectively communicate your expertise and your concern. (21) For students attending universities with DocCom memberships, see also "DocCom" modules 9 (Understands the patient’s perspective), 13 (Responding to strong emotions), 14 (It goes without saying: Nonverbal communication in clinician-patient relationships), and 29 (Alcoholism diagnosis and counseling).

In the following example, the clinician addresses denial directly and uses "reflection" in a genuine attempt to understand and hear the patient’s perspective.

- MD: Hmmm. You are doubtful about my diagnosis of a substance use disorder.
- Patient: I really don't think I have a problem. I know I can stop at any time!
- MD: You are pretty certain that the relationship problems and health issues we have discussed do not come from your drug use.
- Patient: Well, I’m always stressed out with my crazy family, and my horrible boss. I just
need to chill out now and then.

- MD: I hear that even if drug use caused some of the problems, you need drugs to help you chill out. Have I got that right?
- Patient: I'm thinking you are way off, doc.
- MD: You know, as we speak, I get more worried about your health. I could be mistaken, but what you have told me about your situation and the way you are looking at it as we talk sounds like what I have heard from others affected by substance use before they got well. In medicine, we understand that this process is common, and we even have a name for it—"denial". Perhaps I am wrong, but I am deeply concerned, and worry that the disease of substance abuse has taken control of your life. What do you think?
- Patient: Thanks for your concern. What about my rash? It is really killing me.
- MD: I'll recommend an effective, simple treatment for your skin. How can you and I work together to look out for your overall health, now and into the future?

Annotated Video (not shown in print-out text)

TREATMENT OF SUBSTANCE USE DISORDERS

Treatment for substance abuse or dependence requires specialist care from certified counselors or comprehensive community programs or mutual help groups. You should understand the core principles of treatment, so you can best advise your patients.

- Primary care clinicians play a key role in identifying high-risk patients and providing appropriate prevention counseling. When appropriate, family members should be engaged as well.

- Primary care clinicians also play an essential role in referring patients for treatment. Convey to patients that substance use disorders are chronic, relapsing diseases that can be successfully treated and managed and that recovery is a long-term process.

- Effective treatment needs to be individualized, and it includes psychosocial and pharmacological interventions.

- Treatment recommendations need to be staged based on patients’ immediate treatment needs, e.g. brief intervention identifying the diagnosis for the patient, detoxification to manage withdrawal symptoms, residential or outpatient treatment, and 12-step programs.

- Initial and brief interventions include discussions of the results of screening, advice about the need to change substance use behaviors, evaluation of patients’ readiness to make change, negotiation of goals, scheduling of follow-up visits and referral for specialized substance use disorder treatment.

- Assessment and treatment for co-morbid psychiatric disorders are essential components of substance abuse treatment.

Please click the video button on the left to watch George discuss his treatment.

NIDA Treatment Guidelines
The National Institute on Drug Abuse (NIDA) recommends a set of overarching principles that characterize effective substance use disorder treatments. http://www.drugabuse.gov/infofacts/Treatmeth.html

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Buprenorphine and methadone are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. (See also http://www.drugabuse.gov/drugpages/buprenorphine.html and http://www.drugabuse.gov/about/welcome/vivitrol1010.html). For patients with mental disorders, both behavioral treatments and medications can be critically important.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the
acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases; and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

---

**RELEVANT BEHAVIORS**

**ASK:**

1. Screen all patients for past and present substance use.
2. If any use, ask "CAGE" questions for alcohol/drugs, or use NIDA modified "ASSIST" questionnaire.
3. Ask about frequency of use.
4. Ask about method of administration.
5. Ask patients for their perspective on the current and potential consequences of drug use.
6. Ask patients how they acquire their substances, including how they can afford them.
7. Ask about past quit attempts, or attempts to cut down; including withdrawal symptoms, how long abstinent, etc.
8. Ask about current mood and any past mental health problems.
9. Ask patients if they are open to hearing that they might have a substance abuse problem and might need specific help for this.
10. Assess patients' conviction and confidence about their willingness to quit using.
11. Conduct interviews in a non-Judgmental way. (ie: Do not say, "This is really a will-power problem and you need to just quit!" or make other statements that might induce judgment or shame.)

**TELL (Brief Intervention):**
1. Tell patients that you are concerned that they have a substance abuse problem, and need help to manage it. Talk about the potential negative impact of substance use on patients’ health, family, employment, mental health and well-being.

2. Recommend assistance / treatment, and speak succinctly about options: stop on their own, join a 12 step program, go to an addiction specialist, be referred to a treatment center.

3. If patients are on prescription narcotics, negotiate a treatment contract with them.

4. Inform patients about the role of drug and alcohol testing in treatment monitoring.

5. Communicate that individual needs vary, and that treatment usually includes psychological, social, vocational, and biological interventions.

6. Make a supportive statement like, "Recovery is usually a long-term process and it may take years to return to full functioning."

7. Offer to communicate with patients' families.

8. State your willingness to provide continuing care to patients who abuse substances.

**ASK:**

1. Ask patients if they are ready to accept a referral to treatment.

2. Ask patients about their reactions to the discussion.

3. Ask patients about their questions and concerns.

---

**Learner assessment questions:**

1. Define the concepts of tolerance and dependence. How do they differ?

2. What are the common medical co-morbidities of substance use disorders?

3. Define the key principles of screening and assessing substance use disorders in the primary care setting.

4. Describe the skills needed to evaluate patient readiness to accept the diagnosis and treatment recommended.
5. Define how clinician attitudes can facilitate or hinder screening, assessment, diagnosis, and referral of patients with substance use disorders.

When you're done, please enter your name in the field below and click the "DONE" button.
Name:  

**REFERENCES**


Additional resources:

Welcome to DocCom Module 31:
Medically Unexplained Symptoms MUS

by Francesca Dwamena, MD, Felise Milan, MD, Auguste H. Fortin VI, MD, MPH, ; and Robert C. Smith, MD, ScM

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Francesca C. Dwamena, MD, Felise Milan MD, Auguste H. Fortin VI, MD, MPH, Robert C. Smith, MD, ScM

Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.

DocCom implementation: Christof Daetwyler M.D.

Casting of the Standardized Patients: Benita Brown

Standardized Patient Actors: Elizabeth Fuller, Kip Semons

Clinician on camera: Francesca C. Dwamena, MD, Robert C. Smith, MD, ScM
Rationale
Francesca Dwamena, MD

The Patient's View

The Doctor's View
Robert C. Smith, MD, ScM

Questions for Reflection:

1. What do you think about the fact that extensive work-ups fail to explain some patients’ symptoms?
2. How do you feel about caring for patients with persistent Medically Unexplained Symptoms?
3. What personal attitudes or behaviors might limit your effectiveness in managing patients with MUS?
4. Can you resist excessive diagnostic testing with patients with MUS?
5. Can you explain the origins of symptoms to patients?
6. How can managing patients with Medically Unexplained Symptoms improve your
7. What changes can you suggest in the healthcare system in which you practice to improve the diagnosis and treatment of patients with MUS?

Key Principles:

1. MUS are often understandable in the context of patients’ personal histories and current life situations.

2. Only if the clinician shows empathic understanding of distress and suffering - despite frustration or slow progress – will patients with MUS respond to attempts to explain their symptoms or plan treatment.

3. Emphasizing specific steps in planning treatment improves disability, satisfaction and mental health, decreases narcotic use and lowers healthcare costs.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe steps required to establish a diagnosis of “Medically Unexplained Symptoms” (MUS).

- Establish and maintain effective relationships with patients with MUS.

- Assist patients with MUS in understanding their illness.

- Negotiate and agree on specific treatment plans with patients with MUS.

- Assist patients with MUS in making a commitment to actively participate in their care.

WHAT DOES MEDICALLY UNEXPLAINED SYMPTOMS MEAN?

The term “medically unexplained symptoms” (MUS) refers to symptoms that are not adequately explained by the presence of organic disease or pathology, even after an appropriate work-up. Patients with MUS are in emotional distress, and caring for them is difficult or impossible if clinicians ignore or fail to respond to that distress.

Medically Unexplained Symptoms (MUS) refers to physical symptoms that occur without demonstrable organic disease. In patients with demonstrable organic disease, “MUS” refers to symptoms that are out of proportion to or inconsistent with the organic disease. Patients with MUS are a heterogeneous group [1], with a spectrum of presentations ranging from mild to severe. In primary care, MUS is the primary
manifestation of emotional and psychological distress that is unrecognized by the patient. In a national survey, 72% of patients with emotional disorders presented to their clinicians complaining of physical symptoms. [2] Unfortunately, most doctors ignore or fail to respond to patients’ verbal and nonverbal cues and to their silent cries for emotional support. [3]

The term “MUS” is often used interchangeably with “somatization,” a term that has been defined as “the expression of emotional discomfort and psychosocial stress in the physical language of bodily symptoms.” A similar term, “functional somatic syndrome” [4, 5] provoked intense reactions from patients, clinicians, and researchers [6-14]. However, the idea of MUS does not preclude the possibility of underlying explanatory pathophysiologic changes, nor does it preclude that improved scientific understanding in the future could provide organic disease explanations for some of what we now call MUS. MUS should also not be confused with Somatization Disorder, which describes a very small specific group of patients with MUS. The present day understanding of MUS compels clinicians to focus on from emotional distress.

Healthcare providers for MUS patients express frustration, dismay and a sense of helplessness in caring for patients who have what they perceive as “no real disease.” [15-17] Wrongly assuming that patients want multiple diagnostic evaluations, they unwittingly promote further somatization by focusing on symptom diagnosis and alleviation, while ignoring psychosocial cues. [3, 18] Tools for alleviating suffering are described below.

---

**MUS IS COMMON AND EXPENSIVE**

Every clinician (particularly in primary care settings) sees many patients with Medically Unexplained Symptoms. Puzzled or worried clinicians frequently refer patients to specialists, and such referrals result in frequent diagnostic tests and very high medical expenses.

Physical symptoms, such as headache, pain, itching, or swelling are a common human experience. These symptoms are often self-limited and ignored by most people, even though their cause is usually unexplained. Some people are concerned enough to visit a clinician for their symptoms. Examination documents organic disease consistent with the symptoms in only a minority of these ambulatory patients, and most unexplained symptoms do not present a significant problem. In a small but significant minority of patients, MUS manifests as persistent symptoms that remain unexplained even after extensive and thorough evaluation. One investigator estimates the yearly healthcare costs for MUS patients at over $256 billion. As patients with MUS seek to ease their suffering [19, 20], the resulting utilization of healthcare resources is expensive and ultimately fruitless. Patients with persistent MUS report more distress and impairment than similar patients with organic disease [21]. Patient suffering is further exacerbated by skepticism and distrust in both their healthcare [22] and personal relationships [23]. The prevalence of persistent MUS ranges from 1% -33% depending on the setting and definition used [24-26]. According to Katon et al, 25-75% of visits to primary care clinicians were primarily due to MUS. [27]

Specialists recognize MUS, and give various labels to the symptoms [27]. Some common designations are as follows: fibromyalgia, irritable bowel syndrome, chronic pain syndrome, chronic fatigue syndrome, somatoform disorder, non-cardiac chest pain, non-epileptic seizures, and conversion disorder. (see below).

---

**SEVERITY OF MUS SYMPTOMS**
Patients with MUS may have mild symptoms or very severe and persistent ones, and clinicians seldom make the MUS diagnosis, leading to high costs. Patients with severe MUS experience dysfunction in many life domains, and often have a concomitant psychiatric disorder.

A well recognized limitation of the literature on MUS is the lack of a unified standard definition and classification. Nonetheless, the following classification seems useful in helping clinicians to recognize MUS and initiate appropriate treatment.

**Mild MUS**
Patients with mild MUS experience few unexplained symptoms (usually one or two) that last from days to weeks and lead to modestly high healthcare utilization. Clinicians seldom make the diagnosis of mild MUS because patients' symptoms are self-limited. However, instead of further listening in an attempt to understand the full story of the symptoms, clinicians often substitute diagnostic tests. It seems likely that factors such as “stress” and “worry” generate patients’ symptoms, but patients with mild MUS have not been systematically studied, perhaps because they are difficult to differentiate from “normal.” “Mild” patients probably make up 80% of all MUS cases in clinical settings, and if clinicians were able to establish this diagnosis and provide interventions that we discuss below, many laboratory tests, unnecessary treatments and iatrogenic complications could be eliminated.

**Moderate MUS**
Perhaps 15% of all MUS patients in clinical settings have more than 2 unexplained symptoms that endure 1 to 6 months. Such patients with moderate MUS average 8 or more visits a year and undergo extensive testing for their unexplained symptoms. An estimated 20% or more of patients with moderate MUS have psychiatric disorders such as depression, anxiety, dysthymia or substance abuse. They express worries about persistent unexplained symptoms, and many believe they are in poor health. Many patients with moderate MUS have psychological dysfunction that does not meet criteria for a specific diagnosis, and present a significant challenge for their clinicians.

**Severe MUS**
Patients with severe MUS - perhaps 5% of all MUS patients - have multiple unexplained physical symptoms that endure more than 6 months, result in functional impairments and lead to very high testing and referral costs. If primary care clinicians recognize that a patient has severe MUS, they usually lack confidence in their ability to care for that patient. More frequently, clinicians miss the diagnosis, perceive severe MUS patients as “difficult,” and order unproductive tests and consultations. Studies suggest that two thirds or more of patients with severe MUS meet diagnostic criteria for a psychiatric disorder. Investigators studying severe MUS have made the psychiatric diagnoses of “Somatoform Disorder” (includes hypochondriasis, conversion disorder and somatization disorder) or medical diagnoses of “Functional Somatic Syndromes,” (including fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, multiple chemical sensitivities, sick building syndrome, and Gulf War syndrome). However, the validity of these diagnoses has been questioned because of significant overlap in symptom criteria.

---

**WHERE DO MUS SYMPTOMS COME FROM?**
The tools of biomedicine fail to explain the MUS illness process. However, adding the tools of psychodynamics, personality styles, neurobiology and behavior to those of biomedicine – producing the biopsychosocial model – makes possible an understanding of symptom origins and the plethora of patients’ disabilities and dysfunctions.

The failure to explain the origin of physical symptoms puzzles clinicians and dismays patients. [40] Western cultures' acceptance of a mind-body duality demands that clinicians explain what broken body part or system produces symptoms. The duality drives patients' search for legitimate sick roles to access support (“how can my doctor and I fix this broken part?”)

Experiments support the "gate control" theory that provides an overarching biological explanation for unexplained symptoms. This suggests that long-term cortical representations of factors such as family dynamics, socio-cultural influences, past trauma, and prior interactions with providers (see details below) modulate a "gating" mechanism in the substantia gelatinosa in the dorsal horn of the spinal cord. On balance, these central representations lead to less inhibition (a more "open gate") for centrally directed pain impulses (and other impulses) ascending through the spinal cord. While the ordinary person has greater inhibition and feels little pain, the unfortunate MUS patient has less inhibition and more symptoms. The "open gate" makes it more likely that pain and other symptoms become more expected and anticipated. The recurrent anticipation and expectation of pain generates a chronic stress response that produces the suffering experience of the MUS patient. According to recent experimental data, the cortical representations act through a central pain matrix consisting of areas of the orbitofrontal and somatosensory cortices, thalamus and limbic system via multiple neurotransmitters.

The following short paragraphs present research and scholarly thinking about each of the biopsychosocial dimensions that "cause" MUS symptoms and distress.

- Engel [41] eloquently described psychodynamic theories; whose basic premise is that patients' symptoms are symbolic and express an underlying and unconscious conflict. A common scenario is a patient whose symptoms represent punishment; and thus serve to ease unconscious feelings of guilt.

- Some personality traits or styles predispose to development of MUS. [41-43] Histrionic or passive-aggressive styles, for example, are associated with MUS, and may promote misinterpretations of normal body sensations or excessive worry; personality disorders such as borderline personality sometimes accompany severe MUS.

- Neurobiologists think that abnormalities within central nervous system pathways for sensory impulses (particularly for pain) alter patients' perceptions and cognitions of bodily symptoms that occur normally in everyone. [44] Changes have been found in peripheral nervous function associated with visceral hypersensitivity in irritable bowel syndrome [45], and in autonomic and neuroendocrine function in fibromyalgia. [46] Alexithymia, or the inability to express emotions in words, may be neurologically based, as are the depressive syndromes, and both show features of somatization. [47] When depression responds to medications physical symptoms often abate.

- Behaviorists maintain that behavior is often unconscious, adaptive and perpetuated by environmental factors. Somatization behaviors might be an adaptation to family dynamics or social factors such as need for recognition or financial compensation. Some adaptive behaviors may be helpful initially but cause problems such as MUS syndromes if they persist.
Cultures attribute specific meanings to symptoms, and the associated beliefs and attitudes lead some patients to generalize and dramatize somatic complaints. [47, 48]

Violence, particularly sexual abuse, is strongly associated with moderate to severe MUS. Among women with chronic pelvic pain and functional gastroenterological disorders and in patients with chronic pain disorders the frequency of past abuse is as high as 50%. [49, 50] Neurobiological, [51] behavioral, cultural and psychodynamic mechanisms likely contribute to this association. For women in abusive relationships symptoms reduce the abuse (an abuser refrains from mistreating his ill partner). At the same time symptoms may serve as a "cry for help," and allow her to seek care and emotional support from a clinician.

**Discard mind-body duality**

When patients and clinicians think and work as if mind and body are separate, not only do symptoms worsen and costly interventions increase, but also clinicians’ sense of competence diminishes.

The clinician should help patients understand that symptoms derive from many sources, that seldom does an identifiable single cause or "broken part" exist, that efforts to distinguish "mind" contributions to symptoms from "body" contributions are fruitless and that the clinician will strive to help the patient function well in spite of symptoms. Research shows that diagnostic interviews become therapeutic conversations when clinicians empathetically introduce current scientific thinking about the importance of mind-body connections to symptom development in "Western" terms. Patients are more likely to disclose the full panoply of symptoms and their psychosocial context. Further, the strategies that we describe below assist in the resolution of mild MUS symptoms, minimize or prevent the escalation from a "moderate" syndrome to a "severe" one, and help patients live fruitful lives despite symptoms.

**DIAGNOSIS OF MUS**

When patients complain of multiple symptoms of equal importance in unrelated body systems, think of MUS. Spend time on psychosocial history, repeat physical exams, and postpone intensive testing.

As outlined in Modules 5 and 7, clinicians should open every interview by surveying problems and setting priorities for addressing them.

However, when surveying and priority setting seems exhausting and strenuous and patients complain of multiple symptoms of equal importance in unrelated systems, consider MUS syndromes. Then, spending time on a thorough psychosocial history may reveal important clues. For example, symptoms may begin or worsen during a stressful time, such as the loss of a loved one, a job, a dream - or on the anniversary of an important loss. Ask directly,

"How stressful is your life these days?"
"What worries you most about (the symptoms)."
"What do you think (the symptoms) might mean?"
Find out about chaotic or conflicted relationships. Ask if physical or sexual abuse ever occurred or is present in their lives. Ask about past or present substance abuse, or self-medication attempts to lessen symptoms. Perhaps a co-worker just died with similar symptoms? Each of these factors contributes to worrying, adds to distress about what symptoms might mean, and contributes to possible amplification of the symptoms.

In the absence of physical findings related to the symptoms, obtaining simple screening laboratory tests is appropriate. Wait for these results, talk with patients about them, and repeat the physical examination. Symptoms of mild MUS may diminish as time passes and the clinician repetitively uses words and nonverbal strategies to express concern and caring.

---

**Repeat examinations, not tests**

Repetitive thorough examination is therapeutic for patients with MUS. In dramatic contrast, repetitive and vigorous testing delays diagnosis and harms patients with MUS. MUS is a prevalent disorder.

In cases where symptoms persist, a rare or elusive disease such as Wilson's disease, multiple sclerosis, Lyme disease, systemic lupus erythematosus, porphyria, or celiac sprue may be present. Patients with certain diseases— for example, carcinoma of the head of the pancreas, subdural hematoma, or ulcerative colitis may have prominent psychosocial features. Remember that moderate to severe MUS is far more prevalent than the diseases with which it may be confused. Clinicians must sometimes live with uncertainty for extended periods.

However, during repeated examination, patients who have another disease usually develop additional symptomatology or physical findings. The repetition of careful physical exams and symptom reviews not only reassures clinicians, but is therapeutic for patients with MUS. Testing never outperforms careful thinking and carefully repeated examinations in the detection of rare and elusive diseases. Refrain from repeating tests when the probability of negative results is high. Adding new tests, especially invasive tests or consultations, may worsen the symptoms of MUS patients.

As time passes, carefully record ideas and interventions. Without meticulous documentation, clinicians are tempted to repeat unnecessary and negative tests and also fail to make interventions that may help the patient with MUS. It is likely that the sooner appropriate interventions are begun, the more likely patients with MUS are to stabilize or improve.

---

**Co-morbidities with MUS**

Many patients with moderate to severe MUS also have co-morbid conditions, such as symptomatic organic disease, psychiatric disorder, substance abuse or personality disorders.

Trauma, personality factors and psychological stress not only contribute to the development of MUS, as described, but also to the genesis of other disorders, particularly mental health conditions. Co-morbid organic illnesses such as coronary disease, a neurological disorder, or complicated surgeries exaggerate the effects of the above factors. Patients may be in relationship with other professionals, including alternative medicine providers for these conditions. Clinicians should coordinate their
efforts with those other providers.

Organic disease

- **Symptomatic organic disease**: Patients with symptomatic organic disease who also develop MUS pose both diagnostic and treatment challenges. For example, the patient known to have epilepsy may also have non-epileptic seizures that would properly be recognized as part of an MUS disorder. The patient with coronary artery disease may have non-cardiac chest pain and not be appropriately treated for MUS. When patients with MUS develop a new disease such as pulmonary embolism or appendicitis, continue MUS treatment in parallel with other interventions; otherwise, excessive testing and potentially harmful invasive treatments for other conditions will ensue.

Psychiatric Disorders

- **Depression**: Many patients with MUS do meet criteria for a parallel diagnosis of depression. Both disorders require treatment. Depression treatment may reduce the number of somatic concerns, but is not treatment for MUS. MUS treatment should continue simultaneously. Note that undiagnosed depression is not the same as MUS.

- **Panic Disorder**: Panic disorder frequently accompanies MUS. Clinicians must ask about panic attacks (Module 26). Effective treatment of co-morbid panic disorder dramatically reduces symptoms in patients with moderate to severe MUS.

- **Post Traumatic Stress Disorder**: Post traumatic stress disorder (PTSD) is associated with MUS, and some reports show that severe MUS could be 90 times more likely in people with PTSD than in those without. In exploring the depth and breadth of patients’ symptoms, be alert to hints about past or present traumatic situations, such as abusive relationships (Modules 28, 13), cult membership or service in a war zone, and seek consultative help.

Substance Abuse and Personality Disorder

- **Substance Abuse**: Co-existing abuse of substances such as alcohol, benzodiazepines, narcotics, or street drugs is frequent in patients with MUS, especially in those with chronic pain. Interventions for MUS will surely fail unless substance abuse problems are managed in parallel. Many “red flags” signal a co-existing substance use disorder, and include the following:
  
  a) more concern about the drug than the problem,  
  b) claims of multiple medication sensitivities,  
  c) claims of inability to take generic drugs,  
  d) refusal to engage or follow up with diagnostic work-up or consultation,  
  e) sophisticated knowledge of drugs,  
  f) claims by the patient that you are the only one that can help him or her,  
  g) claims of lost prescriptions. (Modules 29 and 30) [53]

Always obtain consultation and refer patients with MUS and substance use disorder to a community resource.

- **Personality Disorder**: One of two signal events may indicate the presence of personality disorder in patients with moderate to severe MUS. The first is failure to stabilize or improve with use of the communication and interaction strategies we outline above and below. The second is when patients’ attitudinal and behavioral problems extend beyond preoccupation and worry about somatic symptoms to a broad range of personal and social situations. Treatment for personality disorder is not in the purview of most clinicians in practice. Obtaining consultation or co-managing with psychiatrists can greatly help in coping with patients’ challenging styles and painful, distressing behaviors.
MUS is the prototype illness in which the clinician is the treatment. (Module 3)[54] Effective management de-emphasizes technical interventions in favor of relationship-building strategies. This is not intuitive for clinicians who seek to “find the broken part and fix it”.

Clinicians who explicitly display sensitivity to the intensity of patients’ suffering facilitate the resolution of mild MUS symptoms. Experience shows that many 21st century clinicians - perhaps even most of them - find that attending to the somatic aspects of patients’ distress is easier than encouraging patients to describe the feelings components of somatic symptoms and then responding empathetically to those emotional aspects. This is not surprising, as they live in a system dominated by mind-body duality and intensive use of technology and procedures. The somatic emphasis is a serious problem because empathetic exploration of both affective and somatic symptoms during “history taking” contributes strongly to “treatment,” producing diminished suffering and symptom resolution. Further, mounting evidence suggests that a predisposed patient may be “turned into” a “somatizer” if the clinician minimizes or fails to recognize verbal and nonverbal cues to the emotions that signal the intense suffering. [55]

Becoming effective with predisposed patients or those with a diagnosis of “mild MUS” requires bringing together certain communication principles outlined in prior modules. The Modules most relevant are Modules 5, on patient-centered interviewing, 9 and 15, on patient perspective and culture, and 6, 13, and 14, on relationship building and non-verbal communication. Full exploration of not only physical symptoms (“bio-”), but also the full emotional and social context (“-psychosocial”) assists in the resolution of mild MUS symptoms, the attenuation of moderate symptoms, and the preparation of more seriously afflicted patients for structured interventions (see MGMT: Major MUS, below). Ignoring or minimizing patients’ suffering delays symptom resolution.

Dr. Smith highlights the therapeutic efficacy of these basic skills in the following videos that show a patient with different symptoms at office visits several months apart.

Both clinicians and patients are often trapped by clinician inability to “fix a broken part” when no “cure” exists for the symptoms. Demands and defensiveness mount, leading to challenging interactions, broken relationships and clinician burnout.

Some patients with MUS believe that a body part is broken, that a really competent clinician would find a cure (drug or surgery), or that caregivers should not “mess with” their minds. Typically, neither patients’ belief systems nor their symptoms respond to rational explanations or simple remedies, so frustration and distrust can mount for both patient and clinician. Clinicians often experience patients as unwilling to cooperate with suggestions and simultaneously as making unreasonable demands. While helping patients become active participants in their care is always an issue, it often seems an impossibility with MUS patients.

Lack of progress is not due to patients’ willful refusal to participate, but to both the dynamics of MUS development and the inevitable communication difficulties. Clinicians who feel discouraged and frustrated are unable to express genuine empathy and stay
in relationship. They may adopt maladaptive behaviors such as avoidance, inappropriate jesting, or being overly controlling or inappropriately passive. These dynamics inescapably lead to negative emotional reactions that are harmful to patients and contribute to clinician burnout.

Effective management requires not only that clinicians reflect on their feelings, but also that they stay attuned to patients’ suffering. Many simple empathic statements can help build relationships with patients, and we list some helpful ones below. Most clinicians will have to both practice them in safe settings and also explore their feelings about “uncooperative and demanding” patients before they are able to use them. Consulting with colleagues will also help avoid making situations worse.

"I will do my best to help you to feel better."
"I am impressed that you can work (or, "get out and around" or," make it to the office", etc) with the symptoms you have- you have a strong constitution."
"you and I have different ideas about why you have these symptoms; let’s talk about them together."
"I sense your frustration that I’m not ordering another MRI at this time."
"Let’s talk about how you can function better with treatments for this pain that do not involve drugs like oxycodone, which would not be appropriate for me to prescribe."
"You are worried that your condition might be serious."
"I can see how you would feel so distressed."
"I see you’ve been through a lot. Thank you for sharing so much about your situation with me."

---

**Set limits; focus on function, not symptoms**

Empathic establishment of certain limits and a steady emphasis on function rather than symptoms also helps to combat relationship challenges raised by the “no cure” dynamic.

Clinicians who plan regular, time-contingent visits - rather than ad-hoc visits based on complaints - show more interest in the patient than in the symptoms. A regular schedule facilitates a stronger focus on improvement in function than a change in symptoms. See patients weekly until they stabilize and begin to make progress. Progressively lengthen visit intervals as tolerated, and shorten visit intervals during times of crises. To avoid reinforcing patient crises, discourage unscheduled visits and instead supplement regular visits with 3 to 5 minute phone calls or short emails.

Establish a consistent visit routine. Once a diagnosis of MUS is established and an initial plan developed, limit follow-up visits to 10-20 minutes. Start with a brief, open-ended, patient-centered update that focuses on the elements described in Management: Major MUS. Physical exam, even a limited one, is highly valued by patients, and should never be neglected. Monitor for potential new diagnoses and integrate the treatment of co-morbid chronic disease like diabetes and hypertension with the treatment of MUS. Remember that patients with MUS are a heterogeneous group [1], and remember that combating societal emphasis on mind-body duality in the service of improving patient function constantly challenges the most competent and empathic clinicians.

---

**MANAGEMENT: MAJOR MUS**
Patients with moderate or severe MUS are extremely concerned, angry, or sad about their symptoms, and often demand tests and procedures. Successful management requires specific protocol interventions - in addition to empathic responsiveness - in order to generate a beneficial and effective partnership.

As noted previously, being alert and responsive to clues that patients give as they describe physical symptoms is a primary aspect of preventing the development of MUS in predisposed people, and of treating those with mild MUS. Clinicians who fail to continually acknowledge the emotional aspects of patients’ suffering not only delay symptom resolution, but worsen the situation. This occurs whether clinicians’ non-response to the emotional aspects is conscious or inadvertent. No patients who sense - consciously or unconsciously- the lack of response to their suffering will be able to cooperate in active treatment. The old saw “We are ruled by our emotions,” dictates that these patients will “doctor shop.” They go on to the next clinician with intensified distress, distrust and demands.

They mistrust clinicians because so many encounters lack empathic acknowledgment of their distress. Effective clinicians make special efforts to listen attentively and accept patients without judgment or prejudice. In spite of patients’ anxiety, sadness and demanding demeanor they are genuinely curious about how patients manage suffering and seek to fully understand their patients’ life situation. When patients question clinicians’ competence and ideas, these clinicians respond to the challenges non-defensively and negotiate and compromise rather than demand and order. [56] They are willing to advocate for patients, but they effectively set limits (above) and are aware of professional boundaries (Module 41). They often and repetitively make statements like those in Management: Relationship, above.

Some specific communication skills that assist in the resolution of mild MUS symptoms, the attenuation of moderate symptoms, and the preparation of more seriously afflicted patients for interventions in the “Major MUS Protocol” below, include the following:

- Respond to both clues about feelings or overt expression of feelings with empathic statements (Name the feeling, show you Understand the feeling, Respect the feeling, Legitimize the feeling, express Partnership and Support the patient.) Details in Modules 5, 6, 13 and 14.
- Conduct a careful and thorough exploration of the physical symptoms themselves- the “biomedical aspects.” Details in Modules 5 and 8.
- Explore the full emotional and social context and patients’ perspectives about origin and treatment of symptoms. Details in Modules 5, 9 and 15.

### MANAGEMENT: PROTOCOL FOR MAJOR MUS

The authors developed a treatment protocol that adds steps specifically designed for complex MUS patients and also incorporates the skills previously described. They confirmed protocol utility by conducting randomized controlled trials.

In randomized studies [57] [58] treatment groups showed clear improvements in physical disability, overall mental health and depression, and decreased use of narcotics and benzodiazepines - compared with controls. Additionally, the interventions
resulted in higher satisfaction with the provider-patient relationship, increased use of full-dose antidepressants and no cost increase.[59] A recent study in Israel using a similar approach demonstrated decline in hospital visits, healthcare expenditures and mortality.[60]

In summary, the trial authors named its elements as education, commitment, goals and negotiation.

**Educate** patients using specific strategies that help them understand that symptoms are not due to a life-threatening process, that their problem has a name, that the symptoms are not "in your head", and that their functioning can be improved despite the symptoms' apparent intractability. Obtain a commitment to become an active participant in treatment. Agree on achievable goals so that progress can be assessed and celebrated. **Negotiate** details of active participation in a specific treatment plan.

---

**Education: share perspectives**

The goal of education is for patients to understand their condition. Simple reassurance is not usually effective. Be optimistic and realistic—"it is possible to manage symptoms and function better, but not possible to cure this illness."

Elicit patients’ ideas about what explains their symptoms and listen to their concerns about what that means for the future (Module 9). Confidently convey to patients that their symptoms and findings do not indicate life-threatening disease and that further testing would not be helpful at this time. Assure them that you believe their problems are real and not "in your head." Name the condition - use a somatic disorder for which some of the symptom criteria are present (e.g., fibromyalgia), or a descriptive name like chronic low back pain.

Ascertain that patients understand that stress can lead to bodily symptoms. Then explain further that their past history of abuse, current stresses or depression produces chronic adrenalin release and muscle spasms, or that chemical imbalances related to depression contribute to increased perception of pain. (see “Causes” above) Share evidence that antidepressants are better than narcotics and tranquilizers for long-term treatment of MUS. Offer an appropriate, plausible mechanism for the symptoms, but remind patients that many mysteries remain about mind-body connections.

We suggest statements and questions that are elements of this process on the next page.

---

**Education statements**

Conversations might include the following elements to legitimize some of patients’ thinking and perspectives, and track associations that could be useful.

- "The good news is that you do not have a life threatening disease and more tests would not add to our certainty right now."

- "You have (name the condition)."

- "I have treated many other patients with this condition."


“This is probably caused by, or at least exaggerated by... (e.g., abnormal wiring in the brain or abnormal muscle contractions).”

“While we are unlikely to cure it, you and I can work together to move it from the center of your life...”

“I see that you are still worried that (e.g. ozone, high-tension wires, microwaves, yeasts) might be causing your troubles, and I know other people blame those things too; however, current evidence suggests (repeat your previous explanations), and I want to keep working at what has been shown to be helpful, so that you can manage better.”

“You are suffering terribly. One thing that would help you and me monitor progress and discover things we might change would be a diary. Would you be willing to write down something about your symptoms each day? Then we can look it over together.”

---

**Ask patient for commitment to active partnership**

Patients will not improve unless they make a *commitment* to active participation in treatment.

Both clinicians and patients are aware of remarkable advances in biomedicine, and eager to find a broken mechanism that might be simply fixed, usually with a drug or procedure. When “finding and fixing” is not possible, managing patients’ symptoms and health requires active participation from both parties. Just as patients with severe organic illnesses who have no specific treatment options left must manage medications well, treat depression, eat well, exercise when possible and keep up their social relationships, patients with MUS must take responsibility for active participation in their non-specific treatments or neither their function nor their symptoms will improve.

Ask patients for an explicit commitment to following plans developed jointly. Anticipate out loud that their efforts will be rewarded in the short and long term, but that since medicine cannot find a broken part, the task is to find ways to improve function. Avoid statements that blame the patient for lack of progress, and show appreciation for any small victories.

We suggest statements and questions that are elements of this process on the next page.

---

**Commitment statements**

Conversations might include the following elements to underscore the need for active commitment and partnership in improving function.

- “*We have treatment that works, but you and I will have to work hard at it together. It is going to be a lot of work, probably harder than you have ever worked on your health, but it will be worth it.*”

- “*Are you on board with this, and willing to carry out your part?*”
“It’s hard to go to exercise class or walk every day (etc), and may take many tries to be successful—just like losing weight or stopping smoking. Let’s look for simple steps in the right direction that you know are likely to work for you.”

“We were both optimistic about taking that next step, but something got in the way. Tell me about what happened for you….”

“Are you really committed to walking? On a 1-10 scale (where 1 is not at all and 10 is total commitment), where would you put yourself? “Why did you not pick a lower number?” “What would it take to help you do better?”

“You seem discouraged. I know your life is miserable—from what I’ve seen. I think you have the strength to keep at this. I know you could be better. What do you think?”

**Agree on goals and assess progress**

Some patients expect the clinician to have the “answers” and may be resistant to a process of joint goal-setting. Engage patients in setting both long-term goals and short term goals, so that they can assess and celebrate progress.

Help MUS patients remember that many illnesses, such as diabetes, hardening of arteries or a stroke are not curable. Like these patients, patients with MUS need to establish realistic long term goals to keep functioning, or improve functioning after setbacks. Living with an incurable illness is hard work and people function better if they decide to pursue goals that they know may have positive effects. Managing blood sugar, avoiding blindness, preventing another stroke, learning to walk or talk again are realistic yet difficult goals. Examples of realistic long-term goals for MUS patients are improved work and school record, relationships, mental health, physical and emotional function, and somewhat improved symptoms.

Achievement of long term goals depends on skill and creativity at negotiating realistic short-term goals. These are the specific day-to-day, week-to-week behaviors that could eventually lead to the long-term success. Exercise, meditation, and diminishing reliance on addictive medications are examples. Work with patients to obtain their commitment to work on a limited number of goals. Devise protocols that enable people to achieve and measure small successes that can be celebrated at the following visit.

Failure to achieve goals is common and predictable, but definitely not a failure of the overall treatment plan. Very often, failures are due to unexpressed ambivalence that results in a "socially acceptable" agreement to do a task, rather than a thoughtful commitment to it. Most patients have difficulty disclosing ambivalence or reluctance, or they may be unaware of it until after the visit. Unanticipated larger or smaller obstacles, such as a partner's disagreement, a new crisis, a sick pet or a snowstorm explain other failures. Some are due to unsuspected substance misuse or abuse. Keeping an "eye on the prize" is essential but difficult when life is complicated by so many elements that hamper even small successes. The clinician's role is to persist at examining and reviewing the total picture, to revise short term goals so that success is possible, and to express hope, empathy and respect.

For clinicians, mindfully maintaining an empathic stance and expressing curiosity, respect and appreciation of patients' positive qualities when progress is absent or fleeting is challenging, sometimes maddening, and yet is one key to their patients' success.
We suggest statements and questions that are elements of this process on the next page.

---

**Goal-setting statements**

Focus the conversation. Keep it practical. Examine the total context. Review any homework. Develop new short-term goals to be achieved by the next visit.

Dialogue about goal-setting will often include statements and questions like the following:

- "What are some of the things you would like to be doing if you weren’t feeling so badly?"
- "What two to three things could you commit to doing over the next one to two weeks?" “Let’s review your homework that we agreed on at the last visit.”
- “You thought that meditating for 5 minutes twice a day would be possible for you. What has gotten in the way?”
- “It seemed that you were ready to walk for 15 minutes twice daily at your last visit. On review, we can see that you had some success, but not at all what we anticipated. Tell me what happened?”
- “I know you were reluctant to cut back on your oxycodone prescription. Has anything else changed over the past two weeks since I cut back your prescription?”

---

**Negotiate specific treatment steps**

Reach agreement on an individualized specific treatment plan. The key aspects of a fruitful negotiation process include the above-described elements of educating, goal-setting and obtaining commitment.

The negotiation process begins as the clinician establishes the diagnosis. Not only do plans usually require several visits to complete and review, but also plan review modification should occur at each visit. In addition to the skills discussed regarding perspectives, exploration and information sharing, clinicians will use skills delineated in Modules 11, 15, 16, and 17 in seeking agreement on a specific plan. For typical patients with moderate to severe MUS, plans usually include some combination of the following actions:

- full dose anti-depressants for treatment of co-morbid depression and/or anxiety
- substitution of non-addicting medications for addicting ones to treat symptoms
- simple physical therapy, exercises or relaxation routines, often designed in consultation with experts
- agreement that the patient will not self-refer to other providers and will take only the medications prescribed in this relationship
Negotiation strategies

During visits, review the plans and negotiate any new elements. Use written contracts to emphasize the importance of the plan’s elements and the partnership.

Dialogue about treatment plans will often include statements like the following:

- "Anybody who has been through what you have been through would be anxious or depressed. We have found that treating depression and anxiety also help significantly to improve symptoms like yours."

- "The medications you are now taking are addicting and as you have seen are not very effective in the long-term... Antidepressants are very effective pain medications"

- "With your permission, I would like to try to slowly wean you off X... and start you on Y... Do not worry. We will go very slowly. My goal is to help you get better, not to get worse."

- "I will go over some specific exercises that have been very helpful for other patients."

- "Before you go to the ER, see other doctors about these problems, change the doses of your medications, or start other medicines, please discuss your ideas with me."

- "Bring your (supportive family member, or supportive significant other) to your next visit."

- "So that we know we are in full agreement about the plans, I’m going to write them out, review them carefully with you and ask you to sign them. That way we’ll have something in writing to reference in our work together."

- "How does this (any of the above statements) sound to you?"

- "Can we agree to make (any of the above statements) part of your treatment plan?"

Treatment
Francesca Dwamena, MD

Dr. Dwamena comments on the videos you are about to see in which Dr. Smith works with a patient with moderate to severe MUS
Consultation and Hospitalization

Cultivate relationships with consultants and peers who understand the dynamics of MUS, who can assist with the frequent interactional and emotional problems and who can help you add to your expertise and facility with managing these complex patients.

Clinicians often need the help of mental health providers and other specialists to perform diagnostic tests or to assist with co-morbid problems or with refractory MUS cases. Partner with consultants who will curtail investigation after an appropriate but not necessarily exhaustive assessment, and who will clearly convey to the patient that no new disease was found and that no further testing is needed. Inform consultants that your patient has or may have MUS so that they can avoid inadvertent reinforcement of the patient’s fears of undiagnosed organic disease.

Patients may worry that referral means abandonment and need explicit reassurance of your continuing involvement and long-term support. Hospitalize patients with psychiatric or physical instability, but not for treatment of symptoms.

__Ms. A (a real patient)__

In the following videos, Drs. Dennis Novack, Carol Landau and their resident team work with Mrs. A, an actual patient referred to their clinic.

Drs. Novack and Landau created the "Problem Patient Clinic" [61] (officially called the "Medical Psychological Consultation Clinic," as a consultative resource and learning experience at Rhode Island Hospital. With residents working alongside them weekly for 12 years they saw patients who had multiple symptoms for which organic disease could not be identified. The team interviewed these patients from one to three times, occasionally making home visits, and then contacted the referring clinician with advice on how to manage the patients more effectively. This approach informed and had many elements in common with the "Educate, Commitment, Negotiate, Goals" paradigm (above), had a positive impact on patient outcomes, and helped clinicians feel less frustrated in caring for these complex patients.

Patients with MUS develop their symptoms over time, and many factors contribute to their onset and maintenance. A careful and focused interview can help you understand how development, family environment, social, financial, and cultural factors, personality and affect interweave to effect expression of multiple symptoms. Such an understanding gives you the basis for designing effective therapeutic interventions and a comprehensive treatment plan. After each video segment Dr. Novack poses questions that can help focus your thinking about the genesis and treatment of medically unexplained symptoms.

After each set of questions, you might want to pause, reflect, and write down your thoughts. It would be helpful to view these video segments with colleagues, as rich discussions and new understanding can emerge. At the end, you should have a better idea of how and why Mrs. A developed her symptoms, what factors keep them going, and what you could do to help her improve her symptoms and her quality of life.

__Video is loading...__
Authors' Discussion
Robert C. Smith, MD, ScM, and Francesca Dwamena, MD

BEHAVIOR CHECKLIST

Focus on relationship
- Explore psychosocial context (use direct open-ended request)
- Ask about emotions (seek deeper understanding)
- Ask for patient’s perspective (use direct open-ended request)
- Empathic response to emotions, suffering
- Commit to partnership
- Negotiate visit limits (length and frequency)
- Discourage unscheduled visits

Education
- Tell a name for condition
- Tell how condition works (pathophysiology)
- Tell that stress is an important factor
- Tell that cure is unlikely
- Tell that improvement in function is likely
- Ask patient’s perspectives
- Tell that this condition is not life-threatening
- Tell why you limit testing

Commitment
- Ask for commitment to partnership
- Tell patient that commitment assures progress
- Check commitment and confidence using 1-10 scales
- Congratulate patient for success, even small success

Goals
- Ask about long-term goals and values
- Ask for short term action plans
- Review progress toward goals
- Ask about impediments to progress
- Emphasize functional improvement, not symptom improvement

Negotiation
- Negotiate visit limits (length and frequency)
- Name co-morbid conditions, and
- Establish agreement to treat co-morbidities
- Establish contracts re other providers and emergency room visits
- Establish contracts re addictive substances and prescriptions
- Involve a significant family member
- Emphasize adherence to schedules

LITERATURE REFERENCES
53. Smith, R.C., et al., Pilot study of a preliminary criterion standard for prescription

Welcome to DocCom Module 32:
Advance Care Planning

by Julie Childers, M.D., Lynn O'Neill, M.D., Eva B. Reitschuler-Cross, M.D.
Credits:

Authors: Lynn O’Neill, Julie Childers, MD, Eva B. Reitschuler-Cross, MD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
doc.com implementation: Christof Daetwyler M.D.
Standardized Patient: Roberta Weiss
Physician on camera: Robert M. Arnold, MD
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A. and Ernesto Matthias de Pina Walde
Video Assoc. Director: Dennis Novack M.D.

Version History:
5.0 - 10/30/2014 Author revision
4.0 - 2/7/2012 Enhanced with HTML5 code and MP4 videos
3.0 - 5/21/2010 Author revision
2.0 - 9/1/2009 Update to doc.com Version 4
1.0 - 7/16/2006

Video is loading...

Rationale
Robert M. Arnold, M.D.

Video is loading...

The Patient's View
Questions for Reflection:

1. Have you experienced any advance care planning (ACP) interviews? How would you begin such a conversation?
2. What are your goals when talking with patients about ACP?
3. What do patients seek in ACP conversations?
4. During conversations about ACP, which patient questions or responses might be most unsettling?
5. How have your personal or professional conversations about living and/or dying with a serious illness prepared you for ACP talks?

Key Principles:

- ACP conversations should begin at a time of relative health.
- ACP conversations are part of routine medical care for all patients with serious illness.
- ACP includes goals of care for the present and for the future; and planning conversations should be revisited as patients’ medical condition change.
- ACP conversations reassure patients, strengthen relationships, diminish potential family conflicts, and guide medical therapy.
- ACP conversations discuss patients’ goals for quality of life, and explore which treatments they are willing to endure to meet these goals.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe nine ways that ACP benefits patients, families and healthcare providers.
- Demonstrate a seven-step approach to ACP.
Focus on patients’ values and goals, rather than treatment options for ACP.

Describe differences between Advance Care Planning and Advance Directives.

INTRODUCTION

An Advance Care Planning conversation explores patients’ current and future healthcare goals and values, as well as their wishes about future treatment options.

An Advance Care Planning (ACP) conversation is an ongoing conversation that begins during a time of health when patients are less vulnerable and the situation less emotionally charged (than when they are ill). Below we list some benefits of ACP. In addition, providers should bring up or revisit ACP in some specific situations, such as the following:

- Patients with serious illness such as cancer, congestive heart failure, chronic obstructive pulmonary disease, neurological conditions like ALS, multiple sclerosis or dementia
- Patients with worsening clinical status, declining functional status, or imminent expected complications
- Patients with frequent readmissions to the hospital
- Members of vulnerable populations whose physicians may not follow a preferred decision-maker’s decisions unless the person is a legally designated health care proxy. Included in these groups are same-sex couples, common-law couples, and single people.
- Use the “surprise” question: Ask yourself, “Would I be surprised if this patient died in the next two years?” If the answer is “no”, then ACP is warranted.

Your role in ACP is to engage patients in thinking about what is most important should their time be limited and to give patients space and time to clarify values and learn more about treatment options. Often patients have not thought much about getting sicker or what might be important to them when gravely ill.

Understanding patients’ preferences, clinicians can recommend treatments and other interventions that are consistent with the patient’s values and goals. ACP conversations can be conducted in either outpatient or inpatient settings as patients’ health status changes over time.

Advance Directives (AD) are any written documents that state patients’ wishes for how to address future medical decisions.

We begin this Module with a focus on suggested steps for conducting Advance Care Planning conversations, and end with discussion of written Advance Directives (AD).

Clinical Scenario:

Kate is a resident on a primary care rotation in Dr. Robert Arnold’s office. Last week, she admitted an 85-year-old man with metastatic lung cancer. He was ill with sepsis and acute renal failure, and intubated in the ICU for two weeks. There was no documentation of any previous conversations about end-of-life wishes. His children struggled to make the decision to take him off the ventilator, as he had never discussed his wishes for end-of-life care with them. Ultimately, he died on the ventilator after a cardiac arrest. She is wondering how this situation could have
been avoided.

Why do ACP?

ACP conversations benefit patients and their entire care-giving team, primarily by generating trust, exchanging information

Your conversations about ACP can address both medical and non-medical goals, build clinician-patient trust, ease conflicts and facilitate decision-making. ACP also prepares patients for diverse and unpredictable contingencies, including loss of decision-making capacity and death. Thoughtful ACP conversations contribute strongly to minimizing burdens on patients, families and all caregivers.

Appropriate documentation of ACP conversations allows clinicians to better advocate for the patients’ wishes, better assist surrogates in making decisions when patients can no longer do so for themselves, and decrease potential conflict with family members and other clinicians.

- We list some specific patient benefits of ACP conversations below. Patients can...
  
  ...clarify their values and consider their feelings about what would matter to them most if facing a serious illness.
  
  ...develop a sense of control and obtain assurance that their preferences are important and will be honored during all stages of their illness, and as they approach death.
  
  ...learn what to expect as they approach living with a serious illness and learn about life-sustaining and palliative care treatment options.
  
  ...help their loved ones and clinicians understand their goals, so that if they lose the ability to make decisions for themselves the healthcare that is provided is consistent with their values.
  
  ...relieve their loved ones of the decision-making burden. Families report both less stress associated with decision-making and more certainty that their decisions are consistent with patients’ goals and values.
  
  ...better prepare themselves for death and find opportunity to reflect about their life’s meaning and accomplishments.

- Now, we list some clinician benefits of ACP conversations. Clinicians can...
  
  ...generate more trusting relationships so that patients can more openly communicate their true hopes, fears and concerns.
  
  ...feel more confident that they are ordering interventions in patients’ best interest.
  
  ...coordinate specific interventions that are consistent with patients’ wishes.

Hindrances to ACP
Despite the universally acknowledged importance of ACP and the benefits listed above, too few conversations are conducted.

As in Kate’s experience above, in the absence of ACP conversations, physicians and families experience frustrations and confusion when patients become seriously ill, and patients’ care is often compromised.

We list some patient barriers to engaging in ACP conversations below. Patients ...

- ...find it emotionally difficult to contemplate a worsening medical condition
- ...cannot predict their future experience of illness, or imagine what interventions such as CPR, mechanical ventilation, or dialysis would feel like.
- ...often change preferences – while feeling healthy they wish for life-sustaining care, but when seriously ill they seek a more comfort-oriented approach. Conversely, patients with slowly progressive serious illness who think they would never want life support may change preferences as they adapt to limitations.

We list some physician barriers to engaging in ACP conversations below. Clinicians...

- ...perceive that ACP talk would take too much time or displace other activity
- ...may be concerned that asking patients to foresee their wishes if they were to get sicker might contribute to their becoming depressed or to losing hope
- ...often feel unskilled about having ACP conversations

Kate asks Dr. Arnold about how he brings up ACP. He says that he is about to meet with Ms. Conners, a patient whom he’s known for 5 years. When they first met she was undergoing cancer treatment, and Dr. Arnold had an initial discussion about advance directives at that visit. He obtained permission from Ms. Conners to videotape that encounter for teaching purposes, and asks Kate to view it now.

Prepare patients

Introduce the topic of ACP by telling patients that you would like to discuss how they would like to handle decision-making if they become unable to make decisions for themselves.

Begin the ACP process by ascertaining whether patients have already designated a health care proxy or established a written plan such as a living will or by completing a Five Wishes booklet (see more on wills and wishes in “Instructional Directives” below). Ask patients if they know whom they want to make medical decisions if they were to become unable to make them. For patients who are unable to communicate because they are too ill, unconscious or mentally incapable, seek information from other clinicians regarding possible prior ACP conversations or written directives.
Assemble people that patients would like to be present and directly but gently open the ACP conversation.

If patients have not made prior plans, begin by explaining that you are raising the ACP because you want to support them, understand and honor their goals and help them achieve those goals. Make certain that the people whom patients want involved in the conversation are present.

Many physicians legitimize the conversation by saying,

"I talk with all my patients about advance care planning and living wills. What do those things mean to you?"

If patients are already seriously ill, put the conversation into the context of the illness process. You might say something like,

"I talk with all my patients about what they would want if they become sicker. What are your thoughts about this?"

"Because this has been a difficult time for you, I’d like your advice about how to handle decisions if you get worse or if you become unable to do so yourself."

Many patients may demonstrate emotion at this time, and physicians should respond with empathic statements, such as,

"I can imagine how distressing this can be. “
"I'm prepared to work with you and with your family, no matter what happens.”

In some studies, 25% of patients say they do not wish to talk about these issues or make decisions about the future. A compassionate response might be

... "Sounds like this is something you do not feel comfortable discussing today. Some people want to be very involved in making these decisions while others don’t. I wonder if there are specific reasons that you find this difficult at this time?"

---

Check perceptions

If you need to update patients’ understanding of their illness and prognosis with new information that they perceive as “bad news,” separate that news from the ACP conversation.

Accurate information helps patients to make decisions that are consistent with their values. For example, patients who understand that their life expectancy is limited are more likely to opt for a comfort-focused approach. Patients’ understanding of their illness process and potential outcomes may be limited or spotty because of overwhelming emotions or because of temporarily limited cognitive ability. At such times it is preferable to focus on clarifying their details of their illness situation and their values. If new information is heard as “bad news,” give patients space and time to process this to mull it over,. This may mean postponing the topic of and take up ACP to a future encounterseparately.

Assess what patients understand, perhaps by asking:
“What is your understanding of your illness?”

“What do you expect will happen in the future?”

“As you think about your situation, what is the best and the worst that might happen?”

Ask patients what they want to know, what concerns they have, and how much detail would be most helpful in their decision-making process.

“What would be most helpful for me to tell you about your situation at this time?”

“Would a ‘general picture’ or a more detailed description be better for you right now?”

**Focus on goals and values**

Your ACP conversations should always be guided by your patients’ goals and values – not by specific interventions.

Satisfactory ACP cannot be undertaken in the absence of information about patients’ values and their treatment goals. Ask patients to explain their hopes for treatment, to say what health state would be acceptable, to describe what makes life worth living, to name the activities they most value, and whether there are personal goals they want to achieve. Ask also about what they would most like to avoid.

Given sanitized and generally optimistic scenarios about CPR and intensive treatment interventions such as dialysis or mechanical ventilation in film and television, few patients can infer what such interventions would mean in their own illness process. A focus on patients’ goals instead of specific treatment interventions gives physicians a better chance to recommend treatments that will help patients achieve their goals.

One way to discover key preferences is to explore patients’ experiences with friends or relatives with serious illness, and to assess the meaning of these experiences.

“What experience do you have of being with someone who was seriously ill?”

“Based on what you saw, what would be your concerns if you were in a similar situation?”

“What makes life worth living for you?”

“What would be most important if your time was limited?”

Discovering which situations are not acceptable to patients is one effective approach to helping patients uncover crucial information on preferences. Typical unacceptable situations include being unable to meaningfully interact with loved ones or living in a facility for the rest of their life. Ask also what risks patients are willing to take to avoid such situations.

“What circumstances might there be in which you would find life not worth living?”

“What situations would you most want to avoid?”

**ASSESS TREATMENT PREFERENCES**

Guide the discussion so that you can understand as thoroughly as possible what connections
patients envision between their goals and their treatment preferences or choices.

As you develop your understanding of patients’ goals and values, questions and speculations about specific treatments inevitably arise. Patients are both curious and worried, and many have personal experiences and knowledge based on months or years of interventions (chemotherapy, congestive heart failure, etc.) for themselves or for family members.

Most patients’ preferences for potentially life-sustaining therapies are hierarchical (from most aggressive and interventional to least). If patients do not want to be readmitted to the hospital, then you probably don’t need to ask for views regarding cardiopulmonary resuscitation. Instead you can simply make a recommendation about resuscitation (see below).

You will be required to balance values and goals alongside preferences for (or against) specific treatments available. Be specific in your inquiry about treatments, and then be curious about what outcomes patients hope for with (or without) a specific intervention. Given that many patients may not understand the implications or specifics of an intervention, the focus should be on the desired outcome of the therapy rather than the therapy itself. Identify what life situations the patient would find unacceptable (e.g. “being a vegetable on a machine”).

Listen attentively to patients’ responses to inquiries such as

"What are your thoughts about chemotherapy at this point?"

"If you get sicker, how would you feel about coming back to the hospital?"

"We should talk about if you want to be put back on the breathing machine if your breathing were to get worse again."

Then fashion your responses in such a way that patients are encouraged to clarify relationships between interventions and values, such as the following:

"I heard you say that you don’t want treatment X: dialysis. Tell me more about your thinking behind this so I know your specific reasons."

"Am I hearing you correctly – are you saying that your goal is to avoid living in a nursing home if that would be a X as a long-term treat arrangement?"

"Under what circumstances might you be willing to undergo mechanical ventilation receive treatment X?"

"You are saying that you wish to avoid more chemotherapy – what do you hope to achieve by declining it at this time?"

Continue to dialogue, eliciting preferences for specific treatments, telling information about the treatments and assessing the patient’s values. You wish to ensure that your patients understand the implications of decisions regarding specific treatments and that you understand the patient’s values.

---

**Artificial nutrition and hydration**

In some states nutrition and hydration are differentiated from other treatments.

Provision of artificial nutrition and hydration is a special case when it comes to which treatments you must ask about. In most states, artificial nutrition and hydration is not considered differently from any other life-sustaining therapy such as dialysis, CPR, or a respirator. In these states a health care proxy can make artificial nutrition and hydration decisions just as with any life-sustaining therapy. However, in other states such as New York, Pennsylvania, and Missouri,
health care proxies require more evidence that they know patients’ specific preferences regarding artificial nutrition and hydration.

(See Appendix 1 for an example of a more specific proxy form.)

**AGREE ON A PLAN**

A successful plan specifies recommendations for interventions that are acceptable and those that will be avoided.

Discuss first what can be done for the patient, rather than what cannot be done.

"I hear that your goal is to continue chemotherapy if it will help you live longer and if you don’t have too many complications. You also want to maximize time with your family. Ultimately, if you get really sick, you’d rather be at home than in the hospital. So I’d recommend that we continue chemotherapy and only admit you to the hospital for treatable conditions like infections. If you get really sick, we will not use machines, because those will not help you meet your goal of being with your family."

When you mention what treatments will be avoided, tell patients and families what will be done instead. This assures the success of the overall advance care plan and will assuage some anxieties of patients and their families.

"If something should happen and your heart stops or you stop breathing while you’re in the hospital, we would give you medications to make sure that you are breathing comfortably and not suffering from anxiety."

Recommend a treatment plan that is aligned both with patients’ goals and with the medical realities.

**Make a recommendation about code status**

Focus conversations about resuscitation around patients’ perspectives regarding an acceptable quality of life. Do not focus on specific interventions.

Experts (12) propose that conversations regarding resuscitation preferences focus on three issues:

- Patients’ quality of life, before any arrest or resuscitation effort
- What patients hope their post-resuscitation quality of life will be
- The probability of successful resuscitation (where "success" is achievement of patients’ hoped for post-resuscitation quality of life)

A recommendation about how to respond in the event of the patient’s death often follows quite naturally once you have assessed the patient’s goals and values.

"Given the importance you place on being at home and not being readmitted to the hospital, my recommendation would be that when death comes, we allow you to die naturally."

Some healthcare facilities have incorporated this language into their orders, using “AND” or “Allow
Natural Death” rather than “DNR”. Every “code status order” – whether “AND” or “DNR” - is a specific example of an Advance Directive, which in this case anticipates the possibility of cardiopulmonary arrest and the patient’s inability to make a considered decision at that time.

(see a more complete discussion on Advance Directives below.)

**Elicit Preferences**

Check goals, by asking “Why this goal?” and telling how you will support their goals.

Ask patients to explain their goals for treatment, and probe for an understanding of what makes their life worth living and what personal goals they want to achieve. Alternatively, ask about their fears and what they would want to avoid. One way to begin such questioning is to explore their experiences with friends' or relatives' end of life care and to inquire how that experience impacts their perspective.

“*What experience do you have of being with someone who was dying?*”

“*Based on what you saw, what, for you, makes the difference between a good death and a bad death?*”

“*What makes life worth living for you?*” “*What would be most important if your time was limited? What would you want to avoid?*”

Another interviewing skill involves reversing the question in order to explore the same issue from a different perspective. For instance, after asking what does make life worth living for the patient, reverse the question and explore what situations they would find unacceptable (e.g., persistent vegetative state) and what risks they are willing to take to avoid such situations.

“*What circumstances might there be in which you would find life not worth living?*”

**CLOSE ACP CONVERSATION**

End an ACP conversation by appreciating of patients’ participation, and stress patients’ autonomy.

Express your appreciation for patients’ willingness to talk about the topic and emphasize that you will remain actively involved regardless of what goals they wish to pursue. Give a clear description of what you will do to meet patients’ goals.

“*I’ve heard you explain that A, B, and C are important to you. I want you to know that as your physician I will do X, Y, and Z in order to help you accomplish these things and that I plan to stay actively involved in your care.*”

Second, stress that you are engaged in an ongoing conversation, and that patients can always change their mind.

“*I want to thank you for helping me understand your values and goals. Have you talked to anyone else about what’s most important to you?*”

“*I want to thank you for helping me understand what’s most important to you as a person and how those values inform the decisions you might make if you get sicker. Over time, patients sometimes change their mind and so I will be sure to check in with*”
Today, Ms. Conners has returned for a follow-up visit. It is now five years after the encounter Kate just viewed. Unfortunately, Ms. Conners' cancer has spread. Dr. Arnold is planning to address Ms. Conners' wishes surrounding her care going forward given this worsening of her disease. He reviews the steps he usually goes through in these conversations.

Annotated Video (not shown in print-out text)

**Document ACP conversations**

Chart your conversation, and if the notes are not accessible by other providers, contact them and share appropriate details.

Be sure to document the context for your conversations, the patient’s goals and values, and the plan, including any pending decisions. At subsequent visits, establish that you are on the same page with patients by reading what you noted in the record.

Kate thanks Dr. Arnold for the learning opportunity to watch and discuss the conversation with Mrs. Conners. Kate says “I really liked that you began by talking about the patient and eliciting what was important to her. Then you were able to make some recommendations that made sense within her context. I think I will try that next time. But I’m wondering how we will make sure these decisions are honored if she goes to the hospital.”

Dr. Arnold answers, “That’s one reason I made sure to send my note to Mrs. Conners herself. Our conversation, and my documentation of it, will be in the medical record. But you’re right. If she goes to another hospital that’s not in our system, they might not have access to the records. On our next visit, I plan to complete a **POLST** form with Mrs. Connors and her husband, and will give them a copy to take home with them on a bright pink page. I tell patients to keep this somewhere where they will remember it, like on their refrigerator. This doctor’s order will be valid across the state.”

**ADVANCE DIRECTIVES**

“Stand-alone” Advance Directives have proven ineffective, but written Advance Directives continue to play an important role when joined with documented Advance Care Planning conversations.

“Advance Directive (AD)”, refers to any written document that states patients’ wishes for addressing future medical decisions. Physicians hoped that AD would be the solution to the troubling situation of unwanted treatments at the end of life, but they proved ineffective for the following reasons:

- Patients are seldom able to think hypothetically about future illness and even less able to predict what type of care they would want
- Patients’ perspectives, goals, values, and preferences often change over time
- The content of many written Directives is either too specific or too vague to apply to the situation at hand.
• Patients who write a Directive often fail to discuss the document, or physicians or families forget such discussions.

In recognition of these limitations, experts underscore the importance of Advance Care Planning conversations, as described in detail above. These conversations may also be recorded as a formal written Advance Directive, and of course the outcomes of conversations will be documented in the medical record.

### Instructional Directives

Instructional directives such as a living will or the Five Wishes booklet permit patients to instruct others about their preferences should they lose capacity to decide for themselves.

The Five Wishes booklet is considered a legal document in 42 states and prompts patients to designate wishes about 5 topics:

- Who they want to make health care decisions if they lose capacity to make decisions themselves
- The kind of medical treatment they want
- How comfortable they want to be
- How they want people to treat them
- What they want their loved ones to know

The workbook section of the Five Wishes prompts patients to choose preferences for life-support treatment in three situations - close to death, permanent and severe brain damage, and coma from which the patient is not expected to recover. Patients can also describe any additional conditions under which they would not want to be kept alive.

The living will is the oldest form of advance directive, devised in 1969 as a way for individuals to express health care desires when no longer able to express current health care wishes. A living will can be very specific or very general. As discussed, this point-in-time document is less helpful than Advance Care Planning conversations.

If patients have already executed an instructional directive, ACP conversation will be facilitated by having them bring that document to the discussion, for review and to ensure that it is still reflective of their wishes given their current health status.

Any instructional directive could include a section for the designation of a proxy decision-maker.

Dr. Arnold now invites Kate in to observe his follow up visit with Mrs. Conners.

### Proxy Directives

Proxy directives designate someone to make medical decisions if patients lose capacity to make decisions, but do NOT specify wishes for care.

The decision-maker is usually referred to as the “health care proxy”, but may also be called a
“durable power of attorney for health care” or a “health care power of attorney.” Proxies’ levels of authority and decision-making responsibility vary by state. In most states, patients’ health care providers cannot serve as their proxy, nor can individuals under the age of 18.

Be sure your patients discuss their health care proxy choice with family members, especially if the proxy choice is unconventional (e.g., if a patients choose a friend rather than a spouse). Of course, the proxy should express willingness to undertake that role, and if possible to be present for ACP discussions with providers, in order to fully understand patients’ wishes.

**POLST Directives**

A POLST (Physician Orders for Life-Sustaining Treatment) form helps ensure that emergency medical personnel and inpatient teams follow patients’ wishes.

Ethicists and other experts designed the POLST program in an additional attempt to ensure that patients’ end-of-life wishes are honored. After originating in Oregon in 1991, the current POLST paradigm creates actionable medical orders that are “translations” of decisions made in conversation and discussion among patents, family members and proxies. Because each state implements its own program (43 as of 2014), specifics such as name (e.g. MOLST, COLST, MOST, and POST), implementation details, and the structure of forms utilized varies widely.

The POLST form, when completed in one setting such as a hospital, clinic, or nursing facility, is transferred with the patient to the next setting, where it can be used as a code status order and to clarify the patient’s pre-existing goals of care. More information about the POLST program: [www.polst.org](http://www.polst.org). See Appendix 2 for examples of POLST forms.

Note that “non-POLST” advance directives are recommended for any adult, provide instructions (but not “orders” in the medical sense) for future treatment, and are not specific about what emergency medical personnel or inpatient treatment teams should do.

**CONCLUSION**

Clinicians who initiate ACP conversations during health – or during illness when patients are still able to think for themselves - enable patients to thoughtfully prepare for unpredictable future possibilities.

Initiate an ACP conversation during health or during illness. Addressing the medical, emotional, and social issues that concern every patient is important because many patients are reluctant to bring up these issues. Key elements in ACP conversations include eliciting patients’ goals and values, attentively and empathetically listening and responding to their preferences, sharing information about available and realistic treatment possibilities and agreeing on a plan that is consistent with patients’ preferences and the current medical realities. While Advance directives have been largely supplanted by documented ACP conversations, Proxy Directives and POLST Directives continue to play a very specific role in ACP.

(APPENDIX 1 PROXY FORM)

(APPENDIX 2 POLST EXAMPLE)
BEHAVIOR SKILLS CHECKLIST

(see DocCom Module 10 for “ask/tell” structure that is used in this skills checklist)

- Ensure appropriate setting and check that relevant people are present
- Ask patients if they have a living will, if they have discussed end-of-life issues with anyone, and if they have a designated healthcare proxy
- Legitimize (normalize) conversations about ACP
- Tell patients that your goal is to be certain that their present and future medical treatment is consistent with their wishes, goals, values and preferences
- Ascertain whether patients are willing to engage in additional ACP conversation
- Ask about patients’ understanding of their illness and prognosis
- Tell patients additional appropriate information and clarify that you both share an understanding of the illness and prognosis
- Tell patients additional information regarding likely treatments
- Ask patients “What makes life worth living,” or “What should be the goals of treatment at the end of life?”
- Ask what life states patients would find unacceptable and what risks they are prepared to take to avoid these states.
- Initiate conversation about specific treatments, such as artificial nutrition and hydration, CPR, mechanical ventilation, etc.
- Ask about patients’ specific treatment preferences, and ask why they have these preferences
- Tell a recommendation and emphasize that you will remain involved regardless of what goals patients choose
- Identify who will be patients’ healthcare proxy
- Tell and reassure patients that uncertainty and confusion are common and that they can change their mind at any time
- Summarize the conversation (include unresolved issues) and check for shared understanding.

LITERATURE REFERENCES

2. POLST – Physician Orders for Life-Sustaining Treatment Paradigm.


---

**APPENDIX 1: Proxy Form (sample)**

Please click the thumbnail below to see a PDF of a sample proxy form.
APPENDIX 2: POLST Form (sample)

Please click the thumbnail below to see a PDF of a sample POLST form.

loading..

loading..

Welcome to DocCom Module 33: "Delivering Bad News"

by Timothy Quill M.D., Carly Dennis M.D., Anthony Caprio M.D., Catherine Gracey M.D.
Facilitator Guide of this module for doc-com Residency Doctoring Curriculum

Credits:

Authors: Timothy Quill M.D., Carly Dennis, M.D., Anthony Caprio M.D., Catherine Gracey M.D.,
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
doc.com implementation: Christof Daetwyler M.D.
Standardized Patients: Robyn George (Patient), Frank Gallagher (Husband)
Clinician on camera: Timothy Quill M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
4.1 - 5/6/2014 - Revision by Timothy Quill, et. al.
3.0 - 2/7/2012 - Enhanced with HTML5 code and MP4 videos
2.1 - 1/21/2010 - Revision by Timothy Quill, et. al.
2.0 - 7/20/2009 - upgrade to DocCom Version 4.0
1.0 - 7/13/2006

Video is loading...

Rationale
by Timothy Quill, M.D.

Video is loading...

The Patient's View
Questions for Reflection:

- How do you feel when you need to tell someone bad news?
- What have been your reactions or your family’s reactions when you have heard bad news in the past?
- If you were receiving bad news, how could whoever is telling it to you help you hear it?
- In thinking about the communication of bad news, what makes it go well; what makes it go poorly? From whose standpoint are you answering this question?
- How can you take care of yourself while attending to the needs of patients and families when you are obliged to deliver bad news?
- What are your fears about illness and death? How might these fears affect your communication of bad news.

Key Principles:

1. Communicating bad news is an everyday clinician task, a core clinical skill.
2. Bad news is defined by the person receiving the news.
3. The way bad news is delivered has a powerful impact on the clinical relationship.
4. The way bad news is delivered is always affected by providers’ feelings (sadness, fear and anger, for example) and by their ability to respond to patients’ and families’ reactions.
5. Using the “6 steps” skills fosters accuracy and empathy during delivery of bad news and builds mutual trust and respect.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe a six-step protocol for delivering bad news
- Demonstrate 4 skillful responses to the expressed feelings of patients receiving bad news
- Name 4 common barriers or pitfalls in delivering bad news
- Demonstrate an understanding of the six steps and the ability to use them in a bad news delivery situation.
INTRODUCTION

“Bad news” is not limited to life-threatening situations. Communicating bad news is an everyday event for clinicians. Balancing the emotional jolt with compassion instead of false hope or vague statements enables patients and families to derive maximum benefit from a trying experience.

Many clinicians find delivering bad news especially challenging when it involves a life-threatening illness. Some clinicians feel uncomfortable with the strong emotions that bad news can elicit both in themselves and their patients. Others feel inadequately prepared or inexperienced, or struggle with their desire to protect the patient and preserve hope, while simultaneously trying to be honest and develop realistic expectations.

Despite these challenges, bad news can be conveyed clearly and compassionately. Effectively breaking bad news can improve the patient’s and family’s ability to plan and cope, encourage realistic goals and autonomy, support the patient emotionally, strengthen the clinician-patient relationship, and foster collaboration among the patient, family, clinicians, and other professionals.

From a patient’s perspective, diagnoses other than life-threatening illnesses may qualify as “bad news”. Anything that has the potential to change someone’s sense of self or health may be bad news; for example the diagnosis of new hypertension. Clinicians know that such conditions are common and usually easily treated, and can easily forget what it means to a patient to hear that he needs to take a medication every day for the rest of his life. Also, the implication of the diagnosis may be very different for a patient if there is a family history of myocardial infarction or stroke. Remembering that whether news is “bad” is determined by the listener, not the giver is an important facet of empathic communication.

We describe a 6 step process for giving bad news, and also discuss special circumstances that commonly arise in the communication of bad news. These circumstances include discussing prognosis, discussing conflict between what the provider and the family think the patient should know, dealing with uncertainty, and telephone notification of death.

COMMUNICATE NEWS AND SUPPORT - A 6-STEP PROTOCOL

We outline and detail a 6-step communication process that builds on what patients already know and what more they are ready to hear. The process respects the need for honesty and attention to individuals’ needs to control the flow of facts and information, as well as to receive emotional support during a painful time.

1. **Advance Planning**
2. **What does the patient know?**
3. **How much does the patient want to know?**
4. **Sharing the information**
5. **Respond to emotions**
6. **Establish a plan and follow up**
Step 1: Advance planning

Before delivering bad news, prepare yourself, prepare patients and families, choose an appropriate setting, and allot time for full discussion.

Prepare yourself. Imagine how your patient might feel, and anticipate typical emotional reactions. Acknowledge your own feelings so that interactions are not driven by your sadness, anger, remorse, or guilt. Review thoroughly basic information about the illness and treatment options. Ensure that all necessary information is available. Rehearse what you will say. Consider bringing a colleague, nurse, or social worker.

Prepare the patient. When ordering a test or treatment, let the patient (and family) know the possible outcomes, including both benign possibilities and more serious ones. This allows the patient and family to prepare psychologically. Also, they may disclose information about the meaning of a particular diagnosis or specific concerns about possible outcomes that will help you respond more accurately and compassionately. Determine whom the patient would like to invite. This might include family, surrogate decision makers, or members of the interdisciplinary team, such as a nurse, social worker or chaplain.

Choose an appropriate setting. Create an environment conducive to effective communication, usually a quiet, private place with adequate seating. Be sure you are comfortably seated at eye level with the patient. Allot adequate time, and avoid interruptions by arranging to hold telephone calls and pages. Patients appreciate evidence that you are not rushing or running away. A box of facial tissues should be handy.

Step 2: What does the patient know?

After initial greetings, have the patient and family tell you what they already know. This provides a basic framework for a patient-centered discussion.

Start by shaking hands, sitting down, and attending to comfort for everyone present. If family members or others you have not met are present, introduce yourself and determine their relationship to the patient.

Then establish what the patient and family already know about the patient’s health and pay special attention to the emotional content of their response to your inquiry. A bad news conversation goes better when you can adjust the presentation of the news according to the participants’ level of comprehension of the situation, and their emotional state.

Questions might include:

- What do you understand so far about your illness?
- What did other doctors tell you about your condition?
- What have you heard so far about what the test showed?
- How serious did you think it might be when...?

Occasionally a patient will fall silent and seem completely unprepared or unable to respond. To ease the situation and stimulate discussion, gently inquire further about what family and patient understand about the situation and recent tests or interventions. In rare circumstances, it may be better to reschedule the meeting for another time, and invite additional support persons.

At times patients may ask you to stop “beating around the bush” and give them the news. This
signifies a readiness to move forward with steps 3 and 4.

**Step 3: How much does the patient want to know?**

Before actually delivering bad news, ask whether the patient is ready for discussion. Asking before telling is respectful and relationship-centered, even though patients may guess that the news is not good based on your tone and facial expression.

Establish what and how much the patient wants to know. People handle information differently and each person has the right to voluntarily decline to receive information. A patient may designate someone else to communicate on his or her behalf. Ask the patient and family how they would like to receive information before telling them.

Possible questions include the following:

- *How much do you want to know about the results of the test?*
- *How much detail would you like me to give you about your condition?*
- *Some people really do not want to be told much at all about their condition, and would rather have family or a friend handle the information. Other people want every detail. Where do you stand on this issue of how much to tell?*

Ask a patient about general preferences for the handling of medical information and decision making early in the clinical relationship before significant information needs to be shared (this is ideally done in the pretest counseling period). This will help the clinician to avoid making a misstep.

"If your condition turns out to be serious, do you want to know? If not, whom should we tell?"

**Step 4: Sharing the information**

If information is clearly bad, precede it with a “warning shot” Share information in small amounts, using unambiguous but not insensitive language, giving patients time to respond to each element you are telling them..

Deliver the information in a sensitive but straightforward manner. Many experts recommend starting with a “warning shot,” which helps to prepare the patient for bad news (such as “I don’t have good news…”). Give the news using easily understood language, and then pause. Avoid delivering all implications of the information in a steady monologue. Provide information in small chunks, pausing frequently to allow silence and time for patient and family to ask questions about each aspect. Do not use technical jargon or euphemisms (i.e. use the word “cancer”, not “carcinoma” or “tumor”). Check often for understanding. Use silence and body language as tools to facilitate the discussion and do not minimize the severity of the situation. Well-intentioned efforts to “soften the blow” may lead to vagueness and confusion. Patients appreciate honesty and straightforwardness as long as it is delivered with compassion. Directness does not imply brutality or insensitivity.

You might choose to break bad news by using language like:

- *I feel badly to have to tell you this, but the growth turned out to be cancer.*
- *I’m afraid the news is not good. The biopsy showed that you have colon cancer.*
Unfortunately, there’s no question about the test results: you have been infected by HIV. The report is back, and it’s not as we had hoped. It showed that it is cancer. I’m afraid I have bad news. The tests show that you had a heart attack.

**Step 5: Respond to emotions**

Strong emotions usually accompany the reception of bad news. Respond to those patient and family feelings with legitimation and empathy. Reinforce your commitment to work through the process over time by answering questions and responding to feelings and distress.

Patients and families respond to bad news in a variety of ways. Responses can be affective (tears, anger, anxiety, fear), cognitive (denial, blame, guilt, disbelief), spiritual (why me?), or even visceral (numbness, disorientation, fight/flight response). Whoever brings the bad news must balance patients’ and families’ needs for information with their needs for emotional support. Keep in mind that their responses may be directed to you as the “messenger” of bad news. Recall that taking a patients’ or families’ anger or sadness personally will not only interfere with their ability to process this information, but also with your ability to maintain a meaningful relationship them.

Expressions of strong emotion make many clinicians uncomfortable. Pause, and give the patient and family time to react instead of trying to limit emotion. Balance the shock with compassion; euphemisms or vague statements produce confusion and are not comforting. Be prepared to support them through a broad range of reactions. Be prepared to support them through a broad range of reactions.

Basic communication skills are useful to respond to emotions. DocCom Modules 6 and 13;

**PEARLS:**

- **Provide partnership**
  
  *We will work through this together.*
  *Is there anyone you would like me to call?*

- **Explore** emotions and be sure you understand before providing reassurance
  
  *Tell me what is most upsetting to you….*
  *Tell me what worries you the most…*

- **Empathize by stating your understanding**
  
  *I imagine it feels overwhelming; maddening; very sad; etc.*

- **Acknowledge** the emotion.
  
  *I can see that this is very upsetting.*
  *You seem overwhelmed by this news.*

- **Legitimize or normalize** the emotion.
  
  *Anyone in your shoes would be upset.*
  *A lot of people would feel angry right now*

- **Provide support**
  
  *I will stay with you.*
  *You will not be abandoned*

Avoid saying, “I understand what you are going through.” No one can truly understand what another person is going through. Remind patients and families that strong emotional responses are normal. Have a box of tissue available. Some patients may express their emotions nonverbally, so be aware of how a patient looks as well as what they say. Some patients may initially “shut down,” perhaps feeling overwhelmed by emotion or by internal reflection about the personal.
meaning of the news.

Quietly listening and “being with” a patient in distress is a helpful nonverbal expression of caring. Consider touching the patient in an appropriate, reassuring manner.

Allow time for the patient and family to express all of their immediate feelings. Don’t rush them. Once the emotion is fully expressed, most people will be able to move on. A shared understanding of the news and its meaning enhances the clinician-patient relationship and facilitates future decision-making and planning.

Sometimes clinicians continue to talk while a patient is shut down or nonverbally expressing emotion. Don't be afraid of silence. If you find yourself talking too much (if the encounter becomes a monologue rather than a dialogue), pause and respond to the associated emotions (“You seem overwhelmed...”) or count silently to 20 in your head. Stopping or slowing yourself helps patients experience your presence and support at a time when they cannot absorb your information.

If the early discussion is all emotion, suggest that the patient may have many questions that you will address at a subsequent visit. If the patient’s initial response is all intellectual, suggest that they may notice strong emotions when they go home, and to call with any concerns.

---

**Step 6: Establish a plan and follow-up**

Make concrete plans with patients about next steps, and include both medical and personal parameters. Address safety issues. Reinforce your commitment and your availability for questions and follow-up.

Establish plans for the next steps. They may include gathering additional information, performing further tests and telling other family members. Arrange for appropriate referrals, and discuss potential sources of emotional and practical support, such as, family, significant others, friends, social worker, spiritual counselor, peer support group, professional therapist, hospice, or home health agency. Reassure patients and family that they are not being abandoned and that you as the clinician will be actively engaged in an ongoing plan to help. Indicate how patients and family can reach you to answer additional questions. Establish a specific time for a follow-up appointment or phone call.

Assess patients’ safety and ensure that they will not be overwhelmed when they leave. Are there medical concerns that need immediate attention? Is a patient able to drive home alone? Is a patient distraught, feeling desperate or suicidal? Is there someone at home to provide support?

Patients and families may not be able to make major medical decisions during an initial conversation, when information sharing is the primary goal. You will probably have an opinion about what decisions could or should be made, but far more important is your provision of support for their decisions (or non-decisions), and your efforts to maintain a therapeutic relationship. This ensures both that the patient and family feel respected, and increases the likelihood that you will be able to provide guidance for their future decisions.

---

**SOME SPECIFIC SITUATIONS**

In this section we cover the following topics
Clinician self-reflection

In order to participate effectively in conversations about bad news, clinicians should review and explore their personal concerns and feelings that are typical in these situations. Some concerns and emotions may be obscure, confusing or discounted.

When the family says "don't tell"
Most patients eventually want to know their diagnosis, but listen carefully to a family's request to withhold information. Assess whether the request makes sense within the family system, culture, or patient values, and respond accordingly.

When language is a barrier
Use an experienced medical translator when delivering bad news to someone who speaks another language. In general, the same 6 step protocol can be followed, but when using a translator, be certain you double-check understanding at each stage.

Tips about communicating prognosis
When discussing prognosis give a range of time that the “average person” with this condition would live (hours to days, days to weeks, 3-6 months, etc), and allow for exceptions. Clinicians tend to be optimistic, so be sure to prepare patients and families that the time could be shorter than anticipated.

Telephone notification of death
Telephone notification about a death is a challenging communication problem, especially if you are a covering clinician without prior interactions with the family. Prepare for the call, identify who should be contacted, and follow the 6-step protocol.(6)

The challenges of clinicians' stating "I'm sorry"
“I'm sorry” is an empathic expression of sorrow, but it can be confused with pity or with an apology, and may shift focus from the patient and family to the clinician.

The significance of clinicians' saying "I wish..."
Wishes stated by clinicians are first and foremost expressions of empathy. The clinician joins the patient and family in wishing that things were different, and simultaneously acknowledges the emotional impact of the loss.

Clinician self-reflection

To participate effectively in bad news conversations, review typical clinician concerns and feelings that surface in these situations. Often, emotions are obscure or confusing, but do explore your personal reactions, whether with trusted people or in solitude.

Clinicians often experience confusing feelings when telling patients bad news. Negative, difficult and conflicting feelings are normal responses to disclosure of bad news. Clinician emotions include a sense of loss of control, a fear of death, feelings of guilt or loneliness, and at times more complex and less discernible feelings. The scope and intensity of emotion varies with the patient, the disease, past experience, and family attitudes. Acknowledge and accept the legitimacy of your own feelings so that you can be fully present and conduct a respectful discussion.

Do not fail to explore your own reactions to bad news conversations. What did the discussion bring up about your own life and your own family? It will sometimes be possible to take time right after a meeting with the patient to do this, other times you will have to wait until the workday is finished. Some people find it helpful to discuss their feelings with a trusted colleague, some people journal or meditate. Provided any identifying details of the case are taken out, it is permissible and often important to discuss your feelings and reactions with a close family member or friend.
When families say "don’t tell"

Most patients eventually want to know their diagnosis and prognosis. Listen carefully to requests to withhold information. Assess whether the request makes sense within the family system, culture, or patient values, and respond accordingly.

Clinicians have a legal obligation to obtain informed consent from patients for procedures and treatments. However, at times family members ask the clinician not to tell the patient the diagnosis or other important information, but effective therapeutic relationships generally require a meaningful alliance with families. Ask them why they don’t want you to tell the patient, what it is they are afraid you will say, or what their experience has been with bad news, rather than confronting their request with “I have to tell the patient.” Inquire whether there is a personal, cultural, or religious context for their concern. Suggest that you go to the patient together to ask how much information is desired about the situation and what questions there might be.

After discussion with the patient, it may ultimately be decided that details of diagnosis, prognosis and/or treatment will be discussed only with the family. However, unless the patient has previously indicated that he or she wants no information, hiding the diagnosis or important information about prognosis or treatment, especially if the patient is asking to be fully informed, is neither ethical nor legally acceptable. These situations may require significant negotiation. In particularly difficult cases, support from the institutional ethics committee or palliative care consultants may be helpful.

When language is a barrier

Use experienced medical translators when delivering bad news to someone who speaks another language. Continue to use the 6 step protocol, but be certain to double check understanding at each step.

This same 6-step protocol for communicating bad news can be used when the patient and clinician do not speak the same language. The assistance of an experienced translator who understands medical terminology and is comfortable translating bad news is required. Do not use family members or untrained bilingual people as translators because this could confuse their roles in the family unit and may violate confidentiality. Also, family members may have personal agendas and responsibilities that lead to miscommunications if they translate.

Brief translators about the nature of the discussion before beginning the interview. If they are not experienced medical translators, reassure them their role is only to translate. Verify that they will be comfortable translating the news you are about to give.

Arrange seating in a triangular fashion so that you can face and speak directly to the patient, yet still turn to look at the translator. Speak in short segments, and then give the translator time to convey the information. Verify that the patient and family understand, and check for an emotional response.

Communicating prognosis
When discussing prognosis, give a range of time, such as hours to days, days to weeks, 3-6 months, etc. Acknowledge that exceptions are frequent, in both directions, and that predictions are often incorrect. Communicate that your personal support will not waver, throughout the illness process.

Patients and family members frequently ask about prognosis. There are many motivations for this request. Some want to have a sense of their future so they can plan their lives. Others are terrified and hope that you will reassure them that things are not so serious.

Before directly answering questions about prognosis, inquire about reasons for asking. Questions might include:

- *How specific do you want me to be?*
- *What experiences have you had with others with a similar illness?*
- *What have you been told about the future?*

Consider the implications of prognostic information you provide. Patients who wish to plan their lives want detailed information, while those who are terrified may do better with more general answers. More definitive answers, e.g., “You probably have about 6 months” are always risky because they produce disappointment if the time proves to be less, and anger or frustration if you have underestimated the patient’s lifespan.

Consider giving a range of time that encompasses an average life expectancy

- “On average patients with your condition live...” “hours to days,” “days to weeks,” “weeks to months,” “months to years,” etc.
- Then follow with, “Of course, there can be exceptions in either direction – you might live longer than expected and we will do everything in our power to make that happen; but you also might live shorter, so you should probably attend to critical matters soon, just in case.”
- Emphasize the limits of prediction, “What this will mean for you I can’t tell. We’ll have a better sense over time how things will evolve for you.”

Good studies show that lifespan estimates, even by the most experienced clinicians, are seldom on target, and often differ from reality by many months, or even years. Clinicians tend to be optimistic in an attempt to preserve hope, and ungrounded optimism fosters a false hope and unrealistic expectations. Always caution patients and families that unexpected surprises can happen. Suggest that it is generally advisable to get critical affairs in order so they won’t be as vulnerable in case things progress sooner rather than later. Reassure them that you will be available to help with issues and support them throughout their illness, whatever happens. Clarify what can be realistically expected and distinguish this from what might be wished for, or what is most feared. Identify the miraculous for what it is—something that happens exceedingly rarely. It may be helpful to say something like “we need to both hope for the best, while we simultaneously plan for the worst. We can’t predict surprises and should plan in case something happens sooner than we are hoping for.”

---

**Death notification**

Notifying people about a loved one’s death is challenging and stressful. This is doubly true for covering doctors who have not had prior interactions with the family. Notifications often take place on the telephone. Clinicians should carefully prepare, identify who should be contacted, and follow the 6-step protocol described above.
Always promptly inform families of a grave turn of events. When patients do die, most agree that it is preferable to present death notification in person. If no family is present in the facility, however, telephone notification is often preferable to delay. If using the telephone, call as soon as possible.

**Prepare carefully for a telephone notification, following the steps below:**

- Positively identify the patient (hospital ID bracelet) and confirm death.
- Obtain relevant information; e.g. patient's name, age, gender, SS# and other ID numbers.
- Obtain the full name, address, phone number(s) of the person/s you are calling. Try to establish from the chart and nursing staff the relationship of the contact to the deceased patient.
- Establish the circumstances of death; expected or sudden. Write down the key information you need and review what you will say.
- Find a quiet or private area.

**Telephone conversation**

1. Identify yourself; ask the identity of the person you are talking to and their relationship to the patient. Ask to speak to the person closest to the patient (ideally, the health care proxy or the contact person indicated in the chart). Until you have verified the identity of the person to whom you are speaking, do not respond to any direct question. Ask if the contact person is alone. Do not give death notification to minor children.
2. Ask what they know about the patient's condition: "What have the doctors told you about ___'s condition?"
3. Provide a warning shot: "I'm afraid I have some very bad news."
4. Use clear and direct but sensitive language, without medical jargon; "I'm sorry, ____ has just died."
   - Use words like "dead" or "died"; avoid using "expired", "passed away" or "didn't make it" which can be misinterpreted.
   - Never deliver the news of death to an answering machine or voice mail. Instead, leave specific contact information. If you cannot make contact within 1-2 hours, contact a hospital representative (e.g. Social Worker).
   - Speak clearly and slowly, allow time for questions; be empathic.
5. If the family chooses to come to see the body, arrange to meet them personally, or designate the best possible person to substitute for you.
6. Provide contact information for the clinician or hospital official who can meet with them and answer questions about the patient's death and other administrative issues.
7. Ask if you can contact anyone for them. Assess their emotional reaction. Briefly assess their safety (suicidality, ability to drive).
8. If you feel uncomfortable about telephone notification, ask for help.

**Not telling the news over the telephone?**

In rare circumstances, it may be appropriate to ask family members to come to the hospital, rather than telling them about a death by telephone. Factors to consider in deciding whether the risk of potential harm from abrupt disclosure of death warrants delaying notification include the following:

- the anticipated emotional reaction of the contact person, based on prior information;
- the contact person's level of understanding;
- whether the contact person will be alone when receiving the information;
- distance, availability of transport, and time of day.

The notifier must decide whether to describe the patient as gravely ill and request that the contact person come to the hospital immediately. If you decide to delay disclosure of the death, make immediate admission of such nondisclosure as soon as you meet the family (e.g. "I'm sorry for not telling you right away over the phone" then give your reason for doing so).
“I’m Sorry”

Saying “I’m sorry” intends to communicate an empathic expression of sorrow, but is easily misinterpreted. Attend to the verbal and non-verbal responses to saying “I’m sorry,” so you can identify and correct misinterpretations.

“I am so sorry that this happened to you.” is generally intended as an empathic expression of sorrow, acknowledging and sharing the sadness and unfairness of the situation. By expressing sorrow, clinicians express their human feelings of connection to the patient – that the patient’s loss has touched them as a person. Clinicians must remain aware that genuine expressions of sorrow can be misinterpreted, and should not be made prematurely.

If “I’m sorry” is said prematurely the statement may shortcut a deeper understanding. Patients’ and families’ own expression of loss may be limited. Perhaps better to begin with “tell me the most difficult part...” (or similar) before expressing empathy with “I’m sorry”.

Below are several ways that the empathic expression “I’m sorry...” can be misinterpreted by patients or families. By paying careful attention to the patient’s verbal and nonverbal response to the clinician’s saying “I’m sorry”, misunderstandings can be identified and corrected quickly if they occur.

- They confuse empathy with sympathy, or even pity, thinking you are saying: “I feel sorry for you”.
- They confuse empathy with apology, thinking you are saying: “I am sorry that I contributed to your suffering; or "I hope that you can forgive me for my role in what happened".
- They think you are changing the subject from patient and family to clinician, looking for them to say: "It’s okay, doctor; you did the best you could".

Hopes and Wishes

Do not give false hope, and, do not deny all hope. Help patients reframe hopes. Make statements that you “wish things were different”, which can simultaneously express empathy and acknowledge the emotional impact of bad news.

Patients frequently make statements about hope during a discussion regarding bad news. Sometimes they say they hope to get well or to live a normal life span, and at other times they may describe feeling a complete lack of hope. Honesty should prevent clinicians from giving false hope, yet denying all hope is just as damaging. The parallel requirement for honesty and hope present a communication dilemma in bad news conversations.

An adequate discussion of hope reflects the fact that goals necessarily change as situations alter. For example, instead of hoping for a long life, focus the patient on hoping for quality of life, freedom from suffering, or living until a certain milestone, if this is plausible. A more general type of hope is a sense that things will get better and that the patient will find peace. Ask patients what they are hoping for and help them to reframe their hopes into something they are likely to receive. (Module 32, 34) Speaking of “wishes” allows patients and clinicians to express a fleeting hope that the patient’s circumstances could be different, to join together and temporarily suspend reality.
By characterizing statements as wishes, the clinician underscores that what is being hoped for is unlikely. This expression, “I wish we had more effective treatment for your condition,” is different from saying something hopeful that may not be connected to reality, such as, “I hope we can find effective treatment.” Whether such statements represent true hope or false hope depends both on the genuineness of the statement, and on the reality of whether effective treatments are available. Do not say, “We are hoping to find more treatment for your condition,” unless there is a reasonable chance of finding such treatment. Instead, express your hope as a wish that simultaneously acknowledges the fact that it is unrealistic. “I wish that we had more effective treatments that we could offer you.” Statements in the form of wishes acknowledge your limited ability to control medical matters and your regret that medicine is not more powerful and effective.

Wish statements are most helpful when they begin a conversation. After such a wish statement, patients might be invited to share their sadness and loss more fully by being asked “What has been the hardest part?” or “As you look to the future, what is your biggest worry?”

Once wishes and disappointments are fully explored, the patient, family, and clinician must begin a search together for new forms of hope and direction that are consistent with the patient’s values. Medicine’s ability to cure or control disease is but one avenue of hope. The search for hope in other dimensions may include living successfully with the disease rather than curing it, exploring experimental therapy (only those which have not been shown ineffective), being free of pain or other symptoms, achieving closure with family members, exploring spiritual or religious issues, or any of a number of personal short-term goals.

CONCLUSION

Learning to deliver bad news with honesty, compassion and attention to individual needs and preferences is a core clinical skill that will only improve if you practice and attend carefully to the impact of your bad news conversations with patients and families.

“I just couldn’t believe he was talking about me.”
(A young patient reflecting back on receiving the diagnosis of gastric cancer.)

Clinicians have the privilege and task of delivering bad news almost every day. Sometimes the news is bad no matter who is receiving it (gastric cancer), and other times it is experienced as bad because of personal experience (hypertension in a patient whose parent had a disabling stroke.) Following a deliberate, six-step process allows the clinician to become prepared, allows the patient to control the flow of information, suggests ways of responding to the emotions that inevitably accompany bad news, and suggests strategies for joining with the patient to create an individualized initial care plan.

BEHAVIOR CHECKLIST

- Prepare yourself in advance of the encounter
• Choose a private space and uninterrupted time, turn off pager.
• Always have tissues available.
• Sit down, shake hands with patient and family.
• Ask what the patient and family already know.
• Ask about readiness to receive news
• Tell a “warning shot;” such as, “I do not have good news.”
• Tell news in simple, direct language; pause
• Attentively listen, allow silence and note nonverbal responses
• Acknowledge, legitimize, and explore emotion before reassuring or telling more
• Tell additional information in small chunks; with pauses to assess reaction
• When telling prognosis, use a range of time; tell that exceptions occur in both directions
• Balance the shock of truthfulness by expressing compassion; do not try to balance by
  distorting grim facts
• Tell key data again in initial conversation, and in follow up visits (patients and families don't
  hear much after the initial diagnosis)
• Establish and agree on a concrete plan for immediate next steps.
• When telling bad news on the telephone, acknowledge emotion, keep call brief, and arrange
  face to face contact
• Tell patient and family that you will make certain they are not abandoned.

REFERENCES

2. Whitney S, McCullough L, Fruge E. Beyond breaking bad news: the roles of hope and
3. Friedrichsen M, Milberg A. Concerns about losing control when breaking bad news to
   2004;292:2516-18
7. Lamont E, Christakis N. Complexities of prognostication in advanced cancer: “To help them
   live their lives the way they want.” JAMA. 2003;290:98-104
   Center @ www.eperc.mcw.edu (accessed 4/20/2014).
9. Quill T, Arnold R, Platt F. "I wish things were different": expressing wishes in response to
11. Participant’s Handbook; Curriculum Module 2: “Communicating Bad News.” © EPERC Project,
    The Robert Wood Johnson Foundation, 1999; Emanuel L, von Gunten C, Ferris F. Education
    for Clinicians on End-of-life Care, 1999.
12. Suchman A, Markakis K, Beckman H, Frankel R. A model of empathic communication in the
    medical interview. JAMA. 1997;277:678-82.
Welcome to DocCom Module 34: "Communication near the End of Life"

by Muriel R. Gillick M.D.

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Facilitator Guide of this module for doc-com Residency Doctoring Curriculum

Credits:

Authors: Muriel R. Gillick M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Standardized Patients: Robin George (Patient), Frank Gallagher (Husband)
Clinician on camera: Muriel R. Gillick M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

5.0 - 6/25/2014 Author revision
4.0 - 2/20/2012 Enhanced with HTML5 code and MP4 video
Rationale
Muriel R. Gillick M.D.

The Patient's View

The Doctor's View
Muriel R. Gillick M.D.

Questions for Reflection:

- Do you avoid talking about palliative care?
- Do you overestimate prognosis when talking with patients?
- Does introducing the topic of hospice care make you feel like you’re "giving up" on patients?
- Do you find yourself using euphemisms when talking about a potentially fatal diagnosis or about end-of-life topics?
- When you plan interventions with seriously ill patients, is one of your goals to “get the DNR order”?

Key Principles:

1. Patients and families highly value your attentive communication
2. Your patients wish to discuss their diagnosis and prognosis
3. To develop optimal plans for care as patients near the end of life, elicit and discuss their goals and priorities
4. Skillful and compassionate referrals to palliative care and hospice services are essential for good end-of-life care

Learning goals:

At the conclusion of this module, you will be able to:

- Communicate effectively and compassionately with patients who are near the end of life
- Communicate news of a serious illness or progression towards death in a sensitive manner
- Discuss prognosis openly, accurately and with empathy
- Elicit your patients’ goals of care, and update goals regularly
- Suggest interventions and limits that are consistent with your patient’s goals
- Describe palliative care and hospice services to patients and families and assist them in deciding to accept referrals

INTRODUCTION

Patients nearing the end of life often feel hopeless and worry they will be abandoned. Clinicians may also feel hopeless, but they can relieve considerable suffering through directed interventions and compassionate communication.

Perhaps the patient with metastatic cancer has failed his third round of chemotherapy or the patient with left main coronary artery disease is ineligible for bypass surgery because of his compromised medical status. Perhaps the patient with dementia responded to treatment of her aspiration pneumonia but then aspirated again a week later. Clinicians sometimes feel they have little to offer such patients as they approach the end of life. Patients in these situations often feel helpless; they feel hopeless, isolated, frightened, and in pain. They turn to their clinician for help in the physical, psychological, and spiritual domains.

In fact the clinician has a great deal to offer. End-of-life care is a critically important, labor-intensive form of medical care. Clinicians who are able to overcome their own sense of helplessness are an invaluable resource for both patients and their families. Directed interventions and compassionate communications allow them to relieve suffering and assure patients that they will not be abandoned.

WHAT DO DYING PATIENTS WANT?

Among patients’ key needs at the end of life are preparation for death and avoiding suffering. Patients and family members say that their physicians seldom offer sufficient emotional support and generally communicate poorly with them.
When patients are asked what matters to them near the end of life, they talk about having trust and confidence in their doctors, about not being kept alive if there is little hope for recovery; and about wanting open and honest communication about their disease. They also want to have good control of symptoms (primarily pain but also nausea, shortness of breath, etc.), to prepare for death by finding a spiritual peace, and to achieve a sense of completion by saying goodbye and making amends. Other factors that patients associate with a good quality of life at the end of life are avoiding hospital or ICU care, meditating, having a good relationship with a clinician, and being visited by a pastor.

When families look back on their relatives’ dying experience, additional themes emerge. Families typically comment that one of the principal deficiencies in care was the paucity of emotional support, from clinicians, in the hospital, in the nursing home and at home. Home hospice care typically provides more support than care in other settings, but still has room for improvement. Both patients and their families agree that discussions with the clinician are particularly crucial—and singularly lacking—during the close of life. One fourth of families report specifically that clinician communication was poor.

Fortunately, we know a great deal about how to communicate in ways that provide the emotional support and comfort that all seriously ill patients wish for.

**Share medical information**

Assuring that patients understand that their clinician thinks they are entering the final stage of life is a complex process, one that requires communicating empathy and support that is individualized to the patient, the family and the medical particulars.

Patients may enter the final stage of life abruptly with a highly malignant brain tumor, or move insidiously into a state of increasing frailty because of a chronic illness. As clinicians perceive that patients are moving toward the end of life, they must share this understanding of the medical facts with patients, and inform them of the important implications for subsequent medical and personal decisions. Telling patients that their underlying health status has changed is an undertaking that must be accomplished with empathy, tact and communication of clinicians’ unwavering support. Include families or significant others in joint dialogues unless such a step is impossible because of geography, culture or other obstacles.

Experts on telling patients such bad news propose six steps that ensure a good process. DocCom Module 33 sets out steps that will communicate support, understanding and accurate information in a compassionate fashion that is calibrated to particular patients’ needs and wishes and puts a plan, however partial and preliminary, in place. If the patient/family do not have questions or say little in response to the news, clinicians may probe gently, and “ask” (see Modules 9 & 10) for their perceptions or their concerns about what they’ve been told. This “ask” will usually elicit responses that allow clinicians to “tell” additional important information that is relevant to the particular situation. When a well established relationship is in place, using humor can be an effective and empathic strategy. Be certain to summarize whatever decisions and plans have been made.

**HOW LONG WILL I LIVE? PROGNOSIS**

Patients want to know how much time they have, but uncertainty is often high, and many clinicians do not talk about prognosis in a skillful and compassionate fashion.
Breaking the news, providing a diagnosis, naming the problem, and planning next steps are all important, but patients cannot make informed medical decisions—or other decisions about their lives—unless they understand their prognosis. In general, patients want to know their prognosis, while clinicians hesitate about prognosticating both because they worry about how to talk about the end of life without “taking away hope” and because they believe their predictions are likely to be inaccurate. However, a review of the medical literature found that while doctors tend to be over-optimistic, their estimates are well correlated with actual survival.

An important barrier to clinicians’ disclosing prognostic information is discomfort with talking about imminent death, quite apart from any uncertainty associated with prediction. Examples of widely used and effective statements are the following:

"Everyone is different, but many patients with your condition only have a little time left." or,

"The statistics show that on average, a patient with your condition lives nine months". This formulation focuses on average life expectancy.

Because of both patient and clinician urgency to gauge prognosis, considerable effort has gone into finding ways to make reasonable estimates. Estimating survival is more difficult with chronic diseases such as obstructive pulmonary disease, congestive heart failure or dementia than with malignancies. However, researchers developed tools that can help with prognostication. One example is the Palliative Performance Scale (PPS), a simple 0 (dead) to 100 (fully intact) scale, that incorporates functional status, disease burden, and cognition. Using the PPS improves prognostic accuracy. The consequences of failing to have a good grasp of reality are striking: in a study of over 900 patients hospitalized with advanced cancer, all of whom had a 50% chance of dying in the next six months, those who believed they were going to live longer than six months were far more likely to request life-prolonging treatment over comfort care. This tendency to seek aggressive measures was prominent in those who believed they had a greater than 90% chance of living longer than six months but whose clinicians estimated the odds at only 10%

ELICIT PATIENTS’ GOALS OF CARE

Ask your patients what is important, and then determine whether their response is more like “life-prolongation,” “maintaining function,” or “maximizing comfort.”

Once clinicians communicate a prognosis, patients are in a position to think about their own goals for their care. Clinicians might introduce this subject by asking,

"What is most important to you at this stage?"

Typically, patients communicate their desire to be at home and to spend time with family; perhaps they will indicate that they do not want to be a burden to others or that they do not want to suffer. After they respond, take the opportunity to deepen the conversation and ascertain whether unresolved conflicts between family members should be addressed, or whether remaining spiritual issues require attention, perhaps with the assistance of clergy.

Continue the conversation by inquiring which of the three major goals of medical care matters most: life-prolongation, maintenance of function, or maximization of comfort. Acknowledge that most patients have all three goals, but that trade-offs are frequently necessary. Prioritizing patients’ goals of care helps clinicians determine which medical interventions would be most appropriate to present for further discussion with a given patient.

Not infrequently, patients and their family members disagree about the goals of care: typically, the patient favors a focus on comfort, but a spouse or adult child wants life-prolonging therapy. As you mediate a family meeting about the conflict, emphasize that you are an advocate for the patient
and that you seek to honor his wishes by facilitating family discussion. Consider offering video decision aids that depict the specific interventions commonly associated with the different goals of care. In one study of patients with advanced cancer who were given a verbal description of the goals of care, 26% said they wanted life-prolonging care, 52% said they wanted basic or limited care, and 22% wanted comfort care; while of those randomized to watch a video, none wanted life-prolonging care, 4% wanted basic or limited care, and 91% wanted comfort care.

**Update goals**

During times when patients’ health declines, tell patients about your perceptions of illness progress and ask again about their priority goals, which often change as the end of life is closer at hand.

At the time of diagnosis of life-threatening illness, patients usually indicate that life-prolongation is their major goal. As long as cure is possible or the disease remains well-controlled, maximal medical therapy may be reasonable – even including treatment in an intensive care unit, intubation or dialysis. Attempts at cardiopulmonary resuscitation may be appropriate in the event of cardiac arrest, though survival is rare in patients with terminal illness.

As illnesses progress, maintenance of function often becomes patients’ priority goal—remaining as independent as possible and continuing to be able to see, hear, walk, and think. At this juncture, clinicians should clarify that vigorous treatment of medical problems will continue, but that CPR, intubation, and ICU care are seldom consistent with this goal.

Finally, when comfort becomes the major goal, clinicians should translate this into medical interventions that are consistent with this priority, such as antibiotics, oxygen, and pain medication, and interventions which are inconsistent with the “comfort” goal, such as surgery, hospitalization, or CPR.

**Arrange consultation with palliative care**

When initial diagnostic steps reveal that a life-threatening illness is present, open conversations about palliative care and arrange a consultation.

Palliative care is a relatively new specialty that focuses on symptom management, psychosocial support, and advance care planning. Palliative care consultation can be helpful at any stage of a life-threatening illness and can be used even as curative therapy is continued.

During conversations about planning for diagnostic and therapeutic steps, talk with seriously ill patients about palliative care. Because it is new, patients and families may think you are declaring that “the end is near,” so you might introduce palliative care using a phrase like this one:

"...an added layer of support for anyone with a serious illness."

A growing medical literature shows that palliative care consultation improves quality of life for patients and may even prolong life: in one study of patients with advanced lung cancer, median survival was 4 months longer in the group randomized to palliative care plus oncologic care than in those receiving standard oncology care alone.
ARRANGE HOSPICE REFERRAL

When patients desire only comfort care, review hospice services with them and their families, and arrange for an intake interview.

As illness progresses and conversations about treatment goals reveal that the patient’s overriding goal is now comfort, it is time to think about a referral to hospice. Hospice programs provide comprehensive care for patients with a prognosis of six months or less who agree to forgo “curative” treatments, and this care is primarily home-based. If the patient expresses interest in remaining at home, the clinician might say,

"You’ve told me you want to be as independent and comfortable as possible. Hospice care is the best way I know to help you achieve those goals. If you agree, a nurse from the program will come to the hospital or to your home and provide further information about their procedures and services."

The benefits of Hospice care are multiple and include a nurse who makes home visits, the availability of an on-call nurse 24/7, emotional support from a team that includes a social worker and chaplain, volunteer support, and bereavement services. The mention of “hospice” connotes imminent death to many people, or may suggest that the primary doctor is “giving up”. In fact, not only can the primary care clinician remain the attending clinician during hospice care, but also services are most effective when patients are enrolled for more than just a few days. Discussions with patients and families will clarify these issues, and include additional important facts such as that opioids, commonly prescribed for serious illness, do not shorten life and do not imply that death is imminent.

NEARING DEATH and SAYING GOOD-BYE

Acknowledge your personal relationship with patients and families as death approaches. Say “good-bye,” and offer assistance to families.

Clinicians often feel sad as a patient nears death, especially when it’s someone for whom they provided care over an extended period of time. Just as we encourage patients who are dying to say goodbye to friends and family, forgiving them for any wrongdoing and making amends themselves, clinicians may wish to say goodbye to a dying patient. This is an opportunity to state explicitly that the relationship has been personally meaningful. You might say,

"It’s been a privilege to help take care of you; I’m going to miss you when you’re gone."

or, “I don’t know if I will see you again. I will always remember the colorful caps you crocheted that you wore when you came to see me after your chemotherapy, and your wry sense of humor.”

A hug – if culturally appropriate (Module 15)- often communicates more than words.

When patients die, the clinician relationship with the their families often comes to an end as well. This represents a second loss. The loss can be slightly mitigated by sending a condolence card or
telephoning family members. Families warmly appreciate an offer to help them with issues such as gaining access to an autopsy report, responding to questions about the actual cause of death or providing help in coping with the death.

CONCLUSION

Communicating news about a diagnosis of life-threatening illness, discussing prognosis, eliciting patients’ goals, translating goals into interventions, providing psychosocial support, and saying goodbye are critically important interventions for all clinicians. Often, specialists such as oncologists, cardiologists, pulmonologists, and others provide much of the care for patients with advanced illness. Primary care clinicians will coordinate with the specialists as they shepherd patients through this intense and emotionally trying phase of life. While the ultimate outcome is death, other goals such as symptom relief and patient and family satisfaction are greatly improved and augmented by steady and skillful communication among clinicians, patients, and families.

BEHAVIOR SKILLS CHECKLIST

- Ask patients what they understand about their current condition
- Tell patients their diagnosis and prognosis truthfully and compassionately
- Elicit patients’ goals and priorities for care during serious illness and as the end of life approaches
- Acknowledge family members’ concerns, help them see the patient’s perspective, and acknowledge the patient’s choices
- Tell patients and families about palliative care and hospice services truthfully and compassionately
- When patients’ goal is comfort care, tell them that hospice is an excellent way to achieve this goal
- Communicate your personal sense of loss and sadness as patients near death

REFERENCES


Welcome to DocCom Module 35: "Dialog about unwanted and tragic outcomes"

by Peter Barnett, MD, MPH
The Patient's View

The Doctor's View

Peter Barnett, MD, MPH.

Questions for Reflection:

1. Imagine that you are a patient, and that a mistake or unforeseen complication occurred during your surgery that will probably require an amputation. Or, imagine that there was an unexpected severe complication due to a medicine that you or a close family member received. What information would you like, and how would you like to be told?

2. ... what could your clinician say and do to help you handle your intense feelings of loss, anger, and blame?

3. If you or a family member or a lawyer wanted to sue whoever made the mistake, what could your clinician or system do to mitigate the intensity of your urge to file suit?

4. Can you imagine communication strategies that your clinician could have utilized in advance of the mistake which might ease your conversations after the mistake is brought to light?

5. Remember a serious mistake that you made (or imagine one) and the subsequent conversations with the patient and family and colleagues. What were (might be) the painful moments, and what could people say or do to mitigate your guilt, shame, anger, and defensiveness?

Key Principles:

1. Contemporary standards of professionalism mandate that clinicians disclose errors and discuss unexpected outcomes. This is true whether I made the error or I discovered an error made by another clinician concerning a patient of mine.

2. Unexpected outcomes can be trivial or tragic, and might or might not involve errors.

3. Collaborative conversations about unexpected outcomes are more likely if the clinician conducts an informed consent discussion in advance of such outcomes.

4. Intense feelings of anger, sadness, blame, shame, distrust and defensiveness are normal when serious unexpected outcomes occur.

5. In the face of tragic outcomes, honest disclosure and explicit acknowledgment of feelings not only help in maintaining a positive relationship, but also reduce malpractice risk.
6. When unexpected outcomes occur, clinicians need personal support from colleagues and administration.

**Learning goals:**

**At the conclusion of this module, you will be able to:**

- List reasons why an informed consent dialogue helps to prevent undesired outcomes.
- Describe ethical and professional principles that support honest disclosure of errors.
- Describe seven key aspects of a disclosure discussion: setting the stage; reviewing background facts; responding to feelings; including everyone; avoiding hedging and conjecture; apologizing; arranging follow up.
- Verbalize respectful responses to the feelings of patients, families and clinicians when communicating about medical error.
- Describe principles for managing common error situations involving other clinicians.

**ERROR IS A SERIOUS PROBLEM**

Both medical errors and unexpected outcomes without error are common and deadly at times. They are due to biologic variability and incorrect judgments in complex situations. Every clinician and health professional makes errors.

According to the Institute of Medicine report medical errors are the 8th leading cause of death in the United States, with medication errors alone accounting for over 7,000 deaths annually.

"Error" often seems difficult to define because illness and medical care are so complex and uncertainty is so prevalent. A medical / legal definition is: “Act of commission or omission with potential negative consequences for the patient that would be judged wrong by skilled and knowledgeable peers at the time it occurred, independent of whether there were actually any negative consequences.” Notice the important role played by medical peers, and that the actual outcome is not relevant.

Many unexpected outcomes result from the biological variability of patient and illness: either the illness appears to be particularly virulent, or the patient resistant to usual treatment. Uncommon, or “low probability” side effects and complications account for many unexpected outcomes. Sometimes clinicians make judgments which prove incorrect, but without negligence; that is, the clinician recommends the wrong path when confronted with significant uncertainties. Some errors result from the complex interactions among members of the healthcare team and systems issues. Finally, every clinician occasionally makes frank errors.

**Patients and clinicians often have differing expectations for success**

Patients and families have high expectations for success and “expectation mismatch” is a major source of complaints and distress.
In some cases patients and families have much higher expectations from treatment than their clinicians do. If these high expectations go uncorrected, an unwanted result might be called “expectation mismatch.”

Clinicians, aware of the complexities of care, may be only slightly surprised by an unanticipated outcome. But the element of surprise may raise doubts and suggest the possibility of error to patients and families, regardless of whether the “risks” were mentioned prior to initiating treatment.

**Unexpected outcomes challenge clinicians**

Clinicians are disappointed and uncomfortable with unexpected outcomes, error or not. They worry about how to talk about them, and about blame, uncertainty and judgments. Clinicians have very high expectations of themselves, quite apart from their ideas of the course of a particular treatment or procedure.

Unexpected outcomes *without* error are rather common, so both patients and clinicians often have experience with them and can call on familiar coping strategies.

On the other hand, when a clear error of any kind results in some unwanted outcome, both patient and clinician experience great discomfort. The patient’s trust is shaken. The presence of error challenges the clinician’s sense of personal and professional integrity. They ask themselves, “Where did I go wrong?” “How could I miss the early warning signs?” They may experience feelings of shame, doubt, sadness and anger at themselves.

Sometimes when caring for a patient we learn about possible errors made by another clinician. Discussion of such situations with patient, family and the previous clinician presents many challenges. Some of the hurdles include fear of precipitating legal action against a colleague or becoming involved in such action, embarrassment during conversation about the situation with the other clinician and managing personal clinical indignation when a serious error has clearly occurred.

Some common concerns of clinicians include questioning the identity of the final arbiter of right and wrong care: who is to judge what appropriate care should be in an individual case? And, since so many errors occur without adverse consequences, how “negative” must the consequences to the patient be before the clinician is obligated to discuss the error with the patient? In addition, many medical errors have complex origins, involving teamwork and “systems” problems. Who is “to blame”?

**MUST PHYSICIANS DISCLOSE?**

Professional standards require that clinicians discuss unexpected outcomes and disclose errors, whether made by oneself or by another clinician.

The responsibility to disclose is based on the intrinsic fiduciary relationship between patient and clinician, and is supported by contemporary ethical standards and accrediting and professional bodies (see below). Furthermore, a clinician who has deceived a patient may not be defended or “covered” by his malpractice carrier. In court, “deception” may be a matter of perception rather than “proof”. Honesty is the best policy.

Not surprisingly, most patients and families want and expect clinicians to discuss problems with treatment promptly and honestly. A personal, non-defensive and open discussion usually reduces
feelings of betrayal and distrust, and anger is often soothed, making the sadness and disappointment more tolerable.

**Mandate to disclose:**

- Joint Commission: requires hospitals to have an explicit policy and procedure for the disclosure to patients of adverse events, complications, with and without error.
- American College of Clinicians: “Clinicians should disclose ...information about....errors...if (it) significantly affects...the patient. Errors do not necessarily constitute improper, negligent, or unethical behavior.”

**Disclosure is unsettling**

Clinicians fear conversations about disclosure, and they are often ill-prepared for them. But cover-up and deception have worse consequences.

Clinicians’ fear of negative consequences from disclosing errors begins early, and pervades the current culture of medicine. In one study, only 54% of residents who made a serious mistake reported it to their faculty attending. Clinicians often react in a “fight or flight” way, based on spontaneous emotional reactions that we hope will protect us—but which seldom are effective, and may actually worsen the situation. We may try to distance ourselves or minimize possible errors: “We all make mistakes...it’s hard to be perfect...” Another defense mechanism is discounting or displacing responsibility: “The hospital does not have enough staff...bad illness...patient did not comply...” Sometimes we attempt to refute even the possibility of error through denial: “Medicine is more art than science...there are only differences of opinion.” Of course, there is usually some element of truth in these statements.

Fear of disclosure operates between residents and faculty as well as between peers, and concealment leads to the problems of secrecy such as fear, anger and retaliation if secrets are discovered. In addition, guilt, shame and withdrawal induced by “cover-up” inhibit learning and quality improvement. Clinicians in teaching institutions and clinicians who are members of interdisciplinary medical teams have a special obligation to model and teach appropriate disclosure and discussion of unexpected outcomes.

In the event of an adverse outcome (or a perceived one), establishing rapport and rebuilding trust with colleagues, team members, patients and families during a disclosure and related conversations is challenging and never simple. The ability to engage empathically, clearly and supportively is greatly improved by simulation and “real-time” practice of the skills outlined in this Module, according to a recent study. We encourage you to take advantage of both simulated and real opportunities for reviewing, learning and practicing the approaches and techniques we discuss.

**Coping can be improved**

Denial, minimizing and deflecting blame can and should be replaced with intellectually honest, supportive and reflective collegial conversations.

Clinicians have many concerns about how to discuss unexpected events, and little experience in managing the difficult emotions that arise. Clinicians usually feel disappointed, and the prospect of a complex and emotion-laden discussion or even a verbal attack increases personal and professional discomfort. They worry about the impact on their lives and practices, teams, institutions and relationships. In part because causality may be hard to assess accurately, unexpected events raise clinicians’ doubts about their own performance, and clinicians worry that
disclosure could awaken the patient’s awareness and suspicions, increasing the likelihood of a malpractice claim.

If you feel you have made a serious error, it can be very helpful to talk with a trusted colleague. Tell your colleague what happened, and your worries and feelings about it. Many errors are errors in retrospect only, and many times your colleagues may tell you they would have made similar decisions. If you made a clear error, talking with a trusted colleague can help you think clearly about it, help you forgive yourself, and learn from the mistake. Denial and avoidance of your feelings can keep you from learning and may prolong your own emotional suffering. Also, in the evolving era of disclosure, discussing the error with your hospital risk management staff provides perspective and helps prepare for your disclosure conversation.

"EXPECTATION MISMATCH" AND INFORMED CONSENT

The informed consent process helps assure that clinician and patient share expectations and basic understanding of the situation, and minimizes the chance of expectation mismatch.

When introduced a few decades ago, informed consent seemed almost a formality, a “cover your butt” piece of paper with some mention of risks, and a signature. This has changed, and present professional and ethical expectations are that the informed consent “form” certifies that patient and clinician have shared an open and frank (but not brutal) discussion. Clinicians use their best communication skills to inform patients as collaboratively and empathically as is feasible. Clinician and patient should have a similar idea of what is most “likely” to occur, and also of what could occur, negotiating expectations along the worst case-best case spectrum to prevent mismatch.

In some institutions it is unclear whose role it is to obtain informed consent - clinician, nurse, resident, or clerk. The clinician is ultimately responsible for the care delivered. Consequently, patients (and lawyers) consider the informed consent process to be the clinician’s responsibility, regardless of who obtains the patient’s signature on the informed consent document.

Elements of informed consent

A consent conversation explores perspectives, options, and uncertainties. Any information that is presented must be tailored according to language, cultural and literacy concerns. An adequate conversation can minimize mismatches, distrust and conflict if disappointing outcomes occur.

Module 17 presents informed decision making in depth. Here we offer a summary of the specific issues related to informed consent discussions. Patients need a clear framing of the clinical issues and discussion of options for diagnosis and treatment, with presentation of potential benefits and risks. Survey uncertainties associated with diagnosis and treatment. Take time to discover whether the patient, the family or the clinician thinks certain alternatives are not “acceptable”.

- Explore the patient’s and family’s perspective (Module 9). Include their ideas about the nature of the disease, concerns about treatment alternatives, prior experience with healthcare, and potential conflicts based on different cultural or social expectations, in order to tailor the care and anticipate future difficulties.

- Tailor information to the patient’s needs and interests in order to establish a shared understanding and mutually agreed plan of action (Modules 10 and 11.)

- Be certain that patients have ample opportunity to raise concerns, especially as you
approach closure, and that they are able to summarize the plan in a way that demonstrates their understanding (Module 12).

- Conversations about complex matters such as treatment with multiple antibiotics or cardiac medications or for hyperthyroidism should be documented in the medical record, even when no patient signature is required. Consent forms signed by the patient that are required for procedures, certain drugs and surgery should include documentation about the conversations that precede the signing.

An effective informed consent dialogue does not prevent disappointing outcomes, but it assures that the patient and clinician have shared their thoughts and concerns about the goals and potential risks of a course of treatments or a procedures. The process strengthens relationship bonds and supports trust, especially in the event of a tragic or very unexpected outcome, with or without medical error. Those bonds and the increased trust permit subsequent conversations to be more open, more dignified and more empathic in spite of the distress.

**ARRANGE DISCUSSION ABOUT UNEXPECTED OUTCOMES:**

After unexpected outcomes, attending clinicians should initiate discussion promptly, arrange an appropriate private setting, engage families, and ensure seating for all participants. Assist residents and obtain administrative support.

In this section you'll find the following topics covered:

1. Begin discussion before initiating treatment
2. Meet Promptly
3. Private setting
4. Engage the family

**Begin dialogue prior to treatment**

Conversation about unexpected outcomes begins prior to treatment, continues during active treatment, and picks up where it left off if unanticipated events ensue. Prior to treatment, the informed consent process serves to minimize misunderstanding and mismatched expectations. During active treatment, the dialogue includes discussion of treatment goals, progress and future planning, with description of any deviations from the expected course of treatment and active elicitation of patients’ concerns.

**Arrange meeting promptly**

As with any “bad news” conversation, arrange a meeting with the patient and family as the clinical situation and circumstances allow, as soon as possible. If telephone discussion is required by the circumstances, tell the basic facts that demand a face-to-face meeting for further talk. Don’t wait
for all the “facts” or for a complaint or question.

“I don’t have all of the information yet, but I need to tell you what I do know at this point. We will meet again as more information is available.”

You may be inclined to postpone, but delays usually magnify problems, and may be perceived as an attempt to conceal or obfuscate issues.

**Private setting**

Talk in a private area, such as a conference room, office or private patient room, and close the door. If conversations begin unexpectedly in a public area such as the emergency department or a hallway, have everyone take a breath and locate a more private area. Privacy is far more important than any inconvenience. Assure seating for everyone, and be especially certain that the clinicians are seated (Module 14).

**Engage the family**

Explore family roles and care-giving relationships, and respond to the family dynamics, conflicts and differences.

The importance of families cannot be overstated, both in the informed consent process and in the event of unexpected outcomes. Family members’ roles differ enormously (Module 20, 32-34), but elicitation and documentation of certain basic information is essential if conversations about unexpected outcomes are to be successful.

Find out what family members, friends, and other clinicians have said and advised. Make an effort to identify difficult relationships and differences of opinion within the family. Make notes about how well you know the family members, their relationships and the living and care-giving arrangements that include the patient.

Clarify what involvement the patient and individual family members feel is beneficial, appropriate, and desirable. When there are differences of opinion or if family ideas are in possible conflict with what you think, discuss these in an open manner. (Module 20)

**DIALOGUE STRATEGIES AND SKILLS**

Bring assistants when discussing serious problems, and assure that any residents who lead such conversations have specific training and guidance.

All staff participants should be prepared: read the chart carefully and know not only the facts of the case but also know which issues remain as yet unclear.

Whenever there is serious injury—with or without error—a second person, preferably from hospital administration, is essential to witness the conversation, facilitate, support the patient and family, and coordinate follow-up. In a non-teaching institution, the attending or covering clinician at the
time of the event takes responsibility for initiating and leading the discussion.

In a teaching hospital or clinic, initiation and leadership depends on the severity and acuity of the situation, the experience of the resident, and any special characteristics of the institution. Inexperienced residents should be adequately prepared and accompanied by a senior resident or faculty clinician as they conduct the conversation. Students may be present, but should not lead discussion. In serious cases, or where there is possible or obvious error, the faculty clinician takes the lead, and negotiates the role of the resident before the meeting. These conversations are a high stakes learning opportunity and careful preparation can assure maximum educational benefit.

---

**Serious injury**

Bring assistants when discussing serious problems, and assure that any residents who lead such conversations have specific training and guidance.

Whenever there is serious injury—with or without error—a second person, preferably from hospital administration, is essential to witness the conversation, facilitate, support the patient and family, and coordinate follow-up. In a non-teaching institution, the attending or covering clinician at the time of the event takes responsibility for initiating and leading the discussion.

In a teaching hospital or clinic, initiation and leadership depends on the severity and acuity of the situation, the experience of the resident, and any special characteristics of the institution. Inexperienced residents should be adequately prepared and accompanied by a senior resident or faculty clinician as they conduct the conversation. Students may be present, but should not lead discussion. In serious cases, or where there is possible or obvious error, the faculty clinician takes the lead, and negotiates the role of the resident before the meeting.

---

**Mindful approach**

Conversation should be timely, but not begun until you have discussed the situation with supportive colleagues or administrators, and taken steps to calm yourself so that you can remain mindful.

In discussion with other personnel, decide who will review the situation, who answers clinical questions, and how to describe different roles. If there are administrative issues and concerns or financial questions, enlist help from administrative personnel. Do not attempt to answer questions you are unsure of, such as whether the hospital will pay for prolonged care.

“I don’t know how to answer your questions about the extra cost, but I will find the right person for these issues.”

Clinicians appropriately anticipate conflict and difficulty when joining the patient and family for discussion of unexpected outcomes. Take a mindful approach and notice your own emotions. Remember prior related events, and especially those when you were in the shoes of patient or family. Remember how and from whom you obtained support then, and anticipate who will support you now. You might begin with deep breaths or other strategies (Module 2, 4) to help settle feelings and calm your mind.

---

**Dialogue elements and sequence**
Take responsibility for introductions, a compassionately delivered opening statement of bad news and an apology. Follow up with a clear summary, attentiveness to patient and family concerns and acceptance of them, check for understanding and continue to respond with empathy.

Take the lead, introduce everyone, and then review their roles and relationships. Warn the patient/family.

“I am afraid I have some bad news.”

Then, a simple initial apology and brief explanation informs people of your compassion and respect for their strengths, which is very helpful at the outset of a complicated discussion.

Patients and families depend on and expect professionalism. At such times of disappointment a professional demeanor includes and demonstrates both attentiveness to others and thoroughness regarding the details. Do not hurry, and especially in situations when you feel urgency, do not allow this to override your attentiveness or give an impression of casualness.

Review the course to date (diagnosis, goals, choices made and why). Recall the informed consent dialogue, but do not suggest that the disappointing event should come as no surprise (it always does). Describe the event succinctly but clearly and pause, indicating your interest in questions and responses. Check for patient and family understanding, and clarify and resolve any differences that emerge. Anticipate common concerns and ask about them, even if others do not initiate discussion.

“What questions do you have about why this happened when things were going so well?”

Listen for and understand the core of the patient’s distress, remembering that their concern may not be immediately obvious, or obscured by confusion or other emotions. Reflect and respond to the emotional messages because these reflections help the patient find her core emotions and express them. Strive for accurate understanding and acknowledgement of feelings, ideas and concerns.

“This is a complex situation. What worries you most?”

Conclude the conversation with a joint discussion about the future. Include a negotiation of the immediate goals and expectations of care and possible complications or risks, and arrange support and future meetings as needed.

“If you have no further questions, let’s talk about the coming days...”

Common Dialogue Dilemmas

With a careful approach and skills practice, clinicians can avoid common communication problems, such as premature reassurance, responding defensively, failing to apologize, and neglecting to talk about who will take continuing responsibility for the patient’s care.

In this section, the following issues are covered:

1. Premature reassurance
2. Feeling defensive
3. Offering apology
4. **Assure continuing care**

**Premature reassurance**

Premature reassurance hinders open dialogue, while empathy and acceptance build trust.

Do not offer premature reassurance, because this is often interpreted as minimizing the experience of the patient and the family.

"I wish I could reassure you that everything will be all right, but I am afraid this might be premature."

Empathize and fully accept disappointments and doubts, using reflective listening and other relationship building skills that foster trust (Module 6, 13) When patients feel understood, upset feelings are soothed. On the other hand, failing to acknowledge strong feelings, trying to minimize them, or turning away from feelings to the facts, even in an attempt to reassure, usually exacerbates strong feelings and hinders open dialog. When the patient indicates he feels that you do understand his distress, review any good news that exists.

"I know that this is very worrisome, but I would also like to describe some reasons for hope."

**Feeling defensive**

Defensive feelings are normal, but expressing them blocks supportive discussion.

Avoid the natural tendency to defend yourself. Express empathy and respect instead of your own defensive feelings.

"It must be hard to trust us after what has happened."

Defensiveness evokes suspiciousness and distrust. Defensiveness has the effect, if not the intention, of appearing to place yourself and your position at the center, in a time of crisis for the patient. Remember that they are the ones who are sick, no matter how sick at heart you may feel.

**Offer apology**

Apology is difficult and complex. Genuine apology is compassionate and expresses sincere concern.

Clinicians often worry that their apology is an admission of fault, or may be construed as an admission of “guilt”. The simplest “apology” might better seen as a statement of compassion and concern, or a general expression of sympathy for the situation.

"I am sorry about what you have been through this week."

"I am sorry things turned out this way". 

Such statements are effective at conveying concern, do not constitute any admission of responsibility and are very important to patients.
A more complex “apology” underscores the fact that you take personal responsibility for your work.

“I am sorry I did not contact you sooner about the laboratory results.”

“I am very sorry that I nicked the bile duct during surgery.”

Clearly this does convey both remorse and responsibility. When there is error involved, this kind of statement is uncomfortable to deliver, but is very reassuring to patients and effective at allaying their worries about your honesty, trustworthiness and potential betrayal of your fiduciary relationship. When there has been error, patients expect an apology, and failing to apologize angers people, sometimes increasing the likelihood of conflict and future claims. In court, your apology is “discoverable”. However, should problems come to court, it is better to have previously acknowledged the discoverable issue than to have it discovered during the litigation process, which convinces people that you wanted to conceal facts and avoid taking responsibility, and increases their anger and vengefulness.

Assure continuing care

Do not fail to assure patients that you will take responsibility for ensuring a continuing care relationship.

When situations turn out badly, patients are apprehensive about feeling abandoned. If they sense that you are pulling away from them, they become angry and more litigious. You and the patient may not have a prior or continuing doctor-patient relationship. If the possibility exists for one, maintain a continuous dialogue and relationship with the patient and family.

“We should talk about the days to come. I need to stay in close communication with you so that you can understand what is happening and I can hear and address your concerns.”

If this is a one-time encounter such as an emergency department visit, or a time/role limited relationship such as occurs in many hospital situations, clarify and reinforce the role of the primary care or specialty clinician who will be assuming care, without minimizing your involvement in the present situation.

“It is important that I speak as soon as possible with your primary care clinician so we can assure continuity of care.”

TRAGIC OUTCOMES AND ERRORS

Unexpected death, any major complication or any error produces very strong emotions and reactivity is high. Clinicians need support setting up and conducting conversations about tragic outcomes.

In conversations regarding “major” complications or clear errors, emotions and disappointment are stronger, particularly the clinician feelings of defensiveness, denial, guilt, remorse and concern about malpractice suits. The strategies and skills described above for unexpected outcomes are appropriate and relevant, but certain elements deserve more emphasis.

Your first priority should be to seek help and advice, particularly to help identify and manage your emotions, and to help you remain mindful of the total picture, not just the present events. Take the time to review the case before you start the discussion, with a focus on what must be done at
this time and what and how much is best to discuss.

Review any training you received on how to respond to and discuss unexpected outcomes and errors in the context of your own institution. Talk with your risk management department, your immediate clinical supervisor or department chair, or other appropriate personnel.

**Honesty, detail, criticism, and empathy**

Dilemmas common to tragic situations include the question of amount of detail needed in the conversation, avoidance of unnecessary controversy, and avoidance of blaming language when another clinician or institution is involved.

Honesty is never wrong, and apology, acceptance of responsibility and avoidance of hedging and blaming are fundamentally important to showing that you care deeply about the patient and family, but judgment is required regarding the level of detail to provide. Remember that too much detail can increase confusion for non-clinicians and make people think there is more that you are covering up. Describe facts and answer questions willingly. Be certain to use language that acknowledges and defines areas of uncertainty.

“**There are some things we know for sure and others which remain unclear...**”

Dishonesty (real or perceived) is noticed, and breeds distrust. Apologize. Be sincere. Accept responsibility without detailed self-critical analysis. Save self-criticism for forums other than with the patient and family; your clarity about what did happen is more important than what might have been. Do not make statements about what you “should” have done, such as, “I really should have reviewed the literature more carefully and maybe obtained a consultation.”

Avoid conjecture that might imply blame.

“**It’s hard to know exactly what I would have done if I had been there...I’m afraid we will have to wait until the situation has been fully investigated.”**

Empathize with disappointments, without taking a position.

“**The impact of this is just so terrible....I wish I could tell you exactly why this all happened.”**

**Transfer, attorneys, discovery**

Offer to transfer care; never talk with patients about your conversation with attorneys or insurers, and remember that all conversations are discoverable except for Quality Assurance proceedings.

When major problems occur, someone always wonders whether a transfer of care is appropriate. Even if patient or family do not bring it up, offer this option as a compassionate response to the pain and other strong emotions that are near the surface. Your offer acknowledges that a natural human reaction might be that continued healthy collaboration could seem too difficult for the patient to manage. Such a respectful offer will not be misinterpreted.

“**I would like to remain your clinician, but I understand you may have some feelings about this. If you would like, I will help you find another clinician.”**

Never discuss with the patient any of your consultations with attorneys, personnel acting under attorney’s direction, or your liability insurer’s personnel; these must be kept confidential. Any
potential or pending disciplinary actions against you or other medical personnel must similarly be kept entirely in confidence.

“\textit{I am afraid I cannot discuss what the hospital investigation has found, but I am happy to answer whatever questions I can.}”

The proceedings of Medical Staff Peer Review committee meetings and case review are protected. However, outside of this protected Quality Assurance arena, the content of informal discussions and meetings such as Morbidity and Mortality conferences are potentially discoverable. HIPAA regulations and associated hospital privacy policies also influence the freedom we have to discuss the details of cases among ourselves. Be sure to consult your practice’s legal affairs department.

\section*{ERROR BY A COLLEAGUE}

In situations where a colleague may have committed an error, respond with empathy and avoid both conjecture and defensiveness. Organize a “disclosure conversation” after obtaining consultation from Medical Director or senior colleagues.

A circumstance that is awkward and sometimes thorny is the assumption of care for a patient who may have been harmed by another clinician’s actions. The patient and the family will typically ask your opinion of the previous clinician’s care. Questions such as:

- \textit{"Was it a mistake for Dr. A to prescribe Drug XYZ that caused this terrible reaction;”}
- \textit{"Dr. A should have prescribed treatment for atrial fibrillation before dad had the stroke, isn’t that right;”}
- \textit{"Why didn’t the radiologist report this finding?”}

When such questions arise, the clinician to whom care is transferred is likely to experience many concerns and emotional responses, including the following:

- \textit{"I am really upset with Dr. A for making this mistake;”}
- \textit{"Dr. A should be ashamed of this;”}
- \textit{"I am ashamed to be working in the same institution as Dr. A;”}
- \textit{"I know Dr. A is too smart to make the mistake the patient is worried about;”}
- \textit{"Did Dr. A really make a mistake?”}
- \textit{"What are the full facts related to this situation?”}
- \textit{"How much can I tell / disclose to the patient?”}
- \textit{"With whom should I (or can I) discuss this situation?”}

Because we seldom know the full story, our sense of professionalism and ethics is challenged – particularly on the occasion when we initially hear about a possible error. Whether an egregious error seems obvious, or the patient seems to have misinterpreted a complex situation, we may be tempted to share our thoughts about a lapse, or conversely, to defend a colleague’s clinical work. We are simultaneously reluctant to criticize a colleague, or to withhold the “truth.” Furthermore, appropriate concerns about potential litigation cloud judgment. This difficult dilemma is common and it usually arises unexpectedly during a busy day. Few clinicians have rehearsed how they might respond professionally and adequately. As with other “difficult conversations,” calling on principles discussed in prior Modules – notably those on strong emotions (Module 13), balance (Module 4), boundaries (Module 41) patient perspective (Module 9) and sharing information (Module 10) fully apply here. Key principles for talking about a colleague’s clinical work include the following:
Disclose what is known for certain, specify what still needs to be ascertained, and avoid conjecture;
- Acknowledge patients’ and families’ emotional reactions, and become aware of your own;
- Call for assistance from administration or the legal department in high risk situations;
- Set up a conversation with the colleague whose care is in question.

Gallagher and colleagues recently published a table of guidelines for choosing participants for conversations: Table 1. Disclosing Harmful Errors in Common Situations Involving Other Clinicians (adapted)

<table>
<thead>
<tr>
<th>For this situation...</th>
<th>Choose these participants...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error by clinician at your institution</td>
<td>Attending clinician and prior clinician</td>
</tr>
<tr>
<td>Error involving trainee or interprofessional colleague</td>
<td>Attending clinician and (if appropriate) whoever made the error</td>
</tr>
<tr>
<td>Error by non-patient contact clinician at your institution (e.g. radiologist)</td>
<td>Attending clinician, and invite the colleague</td>
</tr>
<tr>
<td>Error unrelated to current care (e.g. something previously missed)</td>
<td>Medical Director (or similar); invite current attending clinician</td>
</tr>
<tr>
<td>Error by clinician from another institution</td>
<td>Medical Director (or similar), after consultation with other institution’s Medical Director; invite current attending</td>
</tr>
</tbody>
</table>

Support for Colleagues

The dynamics of supporting colleagues are complex. Approach your colleagues in a non-judgmental fashion, with empathy and respect. Simultaneously, help discover as much of the truth as possible under the circumstances.

In fact, unexpected outcomes are discussed frequently. Discussions range from “morbidity and mortality” conferences and hallway conversations to peer review root-cause analysis and institutionalized support groups. Some resemble an inquisition, others an academic exercise, still others a means of condolence. Conversations among colleagues should mirror those with patients and families: prompt, respectful, honest, empathic, problem-solving, supportive, and with a focus on learning for the future.

Clinicians have specific needs when an error occurs. Carrying life and death responsibility can be lonely, and is never simple. Clinicians feel disappointed and unhappy, and appreciate the opportunity to say so. Clinicians need to understand what went wrong, and how to prevent it in the future. They need to feel understood and supported by colleagues, in both their feelings and their medical practice. Establishing a balance between dealing realistically and honestly about questions of clinical judgment while avoiding contributing to a clinician’s feeling of shame or guilt is as delicate a process as talking with patients and families.

When talking with a colleague who has had a serious adverse outcome, build trust and relationship that can support a frank exploration of the situation. Express empathy:

“I can imagine you feel pretty badly about this.”
Keep it simple; wait for your colleague to respond and do not minimize. Try to facilitate understanding of the case, when and if appropriate. Ask permission first:

“If you’d like, I would be happy to talk about the case with you...I wonder what happened...”

Avoid shame and alienation:

“I’ve made some bad mistakes and know I felt pretty badly afterwards. Still, I hope you don’t feel too ashamed to talk with me about the case. I’ve always respected your judgment and this won’t change our relationship.”

Support your colleague, without condescension:

“What can I do to help you get through this? I want you to know I value our partnership.”

Two movies about having a dialogue with an angry patient who suspects you of being the cause for her suffering

Click on the picture-button above to see a movie **how not to** deal with an angry patient who suspects you of being the cause of her suffering.

Click on the picture-button above to see a movie **how to** deal with an angry patient who suspects you of being the cause of her suffering.

AnnotatedVideo (not shown in print-out text)

**RELEVANT BEHAVIORS**

**Informed consent**

- Check patient’s perspective: what does she believe is the diagnosis and the prognosis without treatment; then share additional information as needed to educate her about the diagnosis.
- Ask the patient what she knows about treatment options, and their benefits and risks, and then share information so that you can assure the patient’s understanding.
- Ask the patient to summarize her understanding of the management plan and ensure that you have achieved a shared understanding.
- Involve the family according to the patient’s wishes.
Unexpected outcomes

- Discuss and review the treatment process.
- Compare treatment progress with treatment goals established during informed consent process.
- Preface disclosure of an unexpected outcome by warning the patient of impending bad news.
- Describe unexpected outcomes (with or without error) succinctly.
- Ask patients how they would like their family involved.
- Actively elicit questions, feelings and concerns, and respond without defensiveness.
- Make empathic statements and use reflective listening skills that acknowledge and accept patients' and families' feelings and concerns.
- When an unexpected outcome without error occurs, express personal concern.
- When an error has been made, accept responsibility.
- When an error has been made, apologize.
- Ask whether the patient is ready to talk about immediate and future care.
- Obtain professional and personal assistance when an error has been made.

LITERATURE REFERENCES


Welcome to doc.com Module 36: "Ending Doctor-Patient Relationships"

by Peter R. Lichstein, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Peter R. Lichstein M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Rationale
Peter Lichstein, MD

The Patient's View

The Doctor's View
Peter Lichstein, MD

Questions for Reflection:

1. Remember a time when you lost someone you depended on for security, nurture and assistance. What feelings were associated with this loss?

2. Take the patient’s perspective--what would be important to you if your clinician of many years was leaving you?

3. What patient characteristics or events might lead you to consider dismissing a patient from your practice?

4. How would you feel and how would you respond to patients request transfer to a new clinician – perhaps communicating that you have not been adequately caring and responsive?
5. What elements would be most important in preparing patients for transfer of care to a new clinician?

Key Principles:

1. Continuity of care and non-abandonment are central principles of all medical care.
2. Clinicians have a duty to minimize clinical, emotional, behavioral and logistical difficulties caused by transfer of care.
3. In both “good” and not-so-good relationships, adherence to relationship centered communication principles promotes mutual respect and satisfactory separations / transfers of care.

Learning goals:

At the conclusion of this module, you will be able to:

- Describe typical psychological and behavioral impacts of clinician-patient separations, for both clinician and patient.
- List 3 patient characteristics that increase vulnerability to transfer of care.
- List 3 topics that should be covered in discussions of transfer of care.
- List 3 reasons why patients request transfer of care.
- Review with a patient the steps and procedures for the transfer of care to a new clinician.
- Elicit patient perspectives and feelings about transfer, and respond with empathy to typical “negative” reactions such as sadness, anxiety and anger.

INTRODUCTION

More frequent and disruptive transfers of care are taking place than ever before. Mobile patients, changes in practice ownership, and continuous insurance and financial fluctuations contribute to the disorder. Clinicians must learn to minimize the adverse consequences for themselves and their patients.

Case 1: Dr. C has cared for Mrs. N, 68, for over 20 years through pneumonia, a myocardial infarction and ischemic colitis, as well as through the death of her husband and estrangement from her daughter. She views Dr. C as her doctor, supporter, counselor and friend. Over lunch, a friend mentions that Dr. C is leaving town for an academic position. Arriving home alone, Mrs. N is anxious and upset. What will she do without Dr. C? And, why didn’t Dr. C have the courtesy to tell her himself?

Dr. C. and Mrs. N. shared a continuous relationship, coming to know each other as doctor and
patient and as persons. Continuity of relationship is a cornerstone of primary care, supporting benefits such as patient and clinician satisfaction, improved health outcomes and cost savings. An ongoing trusting relationship enables both clinician and patient to better confront future challenges.

Today, the vagaries of insurance plans and shifting provider “networks” make it increasingly difficult to maintain continuity in relationships. In the hospital, many patients are cared for by hospitalists whose work schedules interrupt continuity. Patients are more mobile than ever, and relationship continuity is further limited by frequent changes in insurance plan coverage. Patient dissatisfaction with care disruptions may translate into patients requesting a new clinician, and clinicians, in exceptional circumstances, choosing to dismiss a patient.

How do doctors and patients react when the bond between them must be broken, and can we learn to predict, recognize and understand these reactions? In this Module we explore typical reactions to disruptions, terminations and transfers of care as well as communication strategies that have proven effective in managing such separations.

AnnotatedVideo (not shown in print-out text)

ATTACHMENT AND SEPARATION IN MEDICAL SETTINGS

Biologic attachment drive creates strong bonds between people who care for each other. When a clinician breaks bonds by leaving, patients commonly experience separation anxiety. Both tenuous and over-dependent relationships complicate separations and provoke amplified requests for attention or alternatively, excessive independence and noncompliance.

Case 1 (continued): Mrs. N discovered a breast lump several weeks ago, and is unsure why she put off making an appointment--now she wonders if she will be able to see Dr. C before he leaves. Her anxiety grows as she considers facing breast cancer without her trusted clinician.

Bowlby described attachment theory, a framework for understanding responses to disruptions of caring relationships as, “a way of conceptualizing the propensities of human beings to make strong affectionate bonds to particular others and the many forms of emotional distress and disturbance to which unwilling separation and loss give rise. Attachment behaviors serve the biologic purpose of establishing relations of care and nurturance for the very young, the frail and the ill. When these bonds are threatened or broken, separation anxiety is a common response. It peaks during the second and third years of life, but typically resurfaces during times of stress such as illness and hospitalization. Mrs. N encountered feelings of helplessness and dependency when she discovered a breast mass and contemplated separating from Dr. C.

Case 2: After learning that her clinician would be leaving town in several months, Ms. P, age 40, canceled her next appointment. In a letter she told her clinician that saying good-bye in person would be too difficult.

Most patients have trusting, open and secure relationships with their clinicians. Attachments are more tenuous for some and usually reflect earlier relationship difficulties leading to either excessive independence and denial of interpersonal connections (“I don’t need you anyway”) or amplified requests for attention, care and nurture. For Ms. P, the supportive relationship with her clinician was a stark contrast to the abuse she suffered as a child. The prospect of separation was, at least transiently, overwhelming and threatening.

Termination Syndrome
Psychiatrists appreciate that patients may respond to termination of the psychotherapeutic relationship with anger, sadness, anxiety, missed appointments and flares of psychiatric and/or somatic symptoms. This “termination syndrome” has also been observed in primary care.

**Case 3:** Soon after her clinician moved to another city, Ms. V, age 54, repeatedly phoned the emergency number of her HMO requesting urgent care for “pneumonia.” The on-call clinician obtained a history consistent with viral bronchitis and suspected that her symptoms were amplified by anxiety.

**Clinician:** “It sounds like you’re really worried about this cough.” (Naming an emotion)

**Patient:** “I just don’t know what to do. I need to talk with someone.”

**Clinician:** “I notice from your chart that you were Dr. L’s patient. He recently left the practice.”

**Patient:** “I always counted on him to be there for me.”

**Clinician:** “It sounds like you miss him and that makes this illness a lot more frightening.” (Naming an emotion)

**Patient:** “Right. Now I don’t know what to do.”

**Clinician:** “I can appreciate how difficult this is for you. I’m new to the practice and would be happy to take you on as a new patient. How does that sound to you?” (Validation, or Legitimization) (Partnership)

**Patient:** “I’d be so relieved if you would. Thank you!”

The on-call clinician correctly recognizes that Ms. V’s anxiety is connected to the recent loss of her primary care clinician. Her symptoms and demands for urgent care are amplified due to uncertainty about who would care for her. The clinician responds using basic empathy skills. (Module 6)

**Basic empathic relationship skills - PEARLS:**

- **Partnership:** “We will work together in being certain we have identified a new clinician before I leave.”
- **Name the emotion (Empathy):** “I can see this news is pretty upsetting to you.”
- **Appreciate / Respect the patient’s feelings:** “You’ve been a great patient and I’ve enjoyed being your docto
- **Legitimize the patient’s response:** “After the many years that I’ve been your doctor, I appreciate that my leaving raises many concerns for you.”
- **Support:** “I’ll be certain that we smoothly transfer your care to a caring and competenteclinician.”

**Welcoming newly transferred patients**

Mrs V’s difficulties in case 3 remind clinicians to work at smoothing the transition to a new clinician by addressing the emotional and practical consequences of “termination syndrome.”
When seeing a new patient, the alert clinician keeps in mind that patients may carry unresolved sadness, anger, or anxiety stemming from the loss of their prior clinician and this may influence the patient’s willingness to establish a trusting relationship with you. At the initial visit, ask how the patient feels about prior clinicians. Specific questions include:

- “What did you find particularly helpful or useful about your relationship with Dr. L?”
- “What do you miss about Dr. L?”
- “How have you done since Dr. L. left and were you prepared for her/his leaving?”
- “What do you want our relationship to be like? This will be helpful for me to know as we begin our work together.”

These questions are a novel starting point for negotiating a new relationship that incorporates what the patient values from the previous one. Even a brief relationship-centered inquiry communicates your interest in feelings and your openness to discussion of interpersonal matters.

**PATIENT RESPONSES TO LOSS OF A PHYSICIAN**

Separation may precipitate anxiety, sadness, anger or loss of self-esteem. Loss of one’s clinician is particularly destabilizing for patients with chronic illness, psychiatric disorders, social isolation and for those who have had a dependent or conflicted relationship with the clinician.

**Case 4:** Soon after learning that his clinician, Dr. W. would be leaving, Mr. H. began calling the practice frequently for medication renewals, to report new and “worrisome” symptoms, and to demand an immediate response from his doctor. Dr. W. was concerned that a flare of medically unexplained symptoms might indicate a missed diagnosis or perhaps a relapse of the patient’s substance abuse. Dr. W. noticed that she was putting off returning Mr. H.’s calls. On top of the added time demands of closing her practice, Dr. W. became aware that emotion laden interchanges with patients was exhausting, particularly with demanding and “needy” patients such as Mr. H. She even wondered if her practice style had promoted patient dependency.

The frequent visits and shared experiences that accompany complex medical conditions build relationships and trust that are not easily transferred to another clinician. Vulnerable patients express their anxiety, sadness and anger through a variety of behaviors. Like Mr. H, the wish to keep the clinician from leaving is expressed through the “body language” of physical symptoms and requests for care. Other common reactions include:

- Anger: Accusations that the clinician is irresponsible or uncaring.
- Sadness: Worsening of an underlying affective disorder, withdrawal and low self-esteem (“I’m not worth taking care of”).
- Anxiety: Heightened somatic awareness with misinterpretation of normal physiologic processes as symptoms of disease, and urgent requests for care
- Gaining Control: “Leaving before I’m left” (Case 2 is an example).
- Denial of emotional response: (Case 5)
- Deterioration in adherence to care plan and resumption of risky behaviors

**Minimize the impact of transfers**

Initiate discussion, tell patients sooner not later, raise the topic early in an encounter, listen
attentively and legitimize the full range of potential negative emotions. Consider this discussion as similar to the delivery of “bad news” and use similar strategies.

You must initiate discussion about an impending separation, even if reluctant to spend time this way. Acceptance of patients’ responses in an empathic and nonjudgmental manner helps patients recognize, explore and resolve the loss. Incoming clinicians will be especially grateful, because such talks help patients avoid maladaptive behaviors that bedevil attempts to establish a new therapeutic relationship.

Tell patients you are leaving sooner, not later. One approach is to inform patients as soon as your decision is certain. Another is to tell patients no later than their next-to-the-last visit. Vulnerable patients always benefit from earlier disclosure that allows them time for emotional adjustment and logistic planning.

Doctors, like patients, sometimes inadvertently leave important topics to the end of a visit. Make your leaving a specific agenda item and bring it up early in a visit so that you have time for dialog. The pitfalls of ending an encounter with, “Oh, by the way, I’ll be leaving the practice next month” are obvious.

Listen in a nonjudgmental and non-defensive manner, and legitimize (normalize) negative responses. Expressing “negative” emotions is easier for patients whose clinicians tell them that it is normal to feel anxious, angry, or abandoned when their doctor leaves. This legitimization invites patients to speak openly and often helps them resolve prior conflicts with the doctor and move forward with their care.

**Employ communication strategies similar to those used in breaking bad news.**

- Begin with a brief, clear statement that you are leaving and when; do not elaborate initially.

- Allow a period of silence so patients can assimilate the news and respond. Elaborating, asking questions or providing reassurance at this time interrupts the intimacy created by sharing silence. Physical touch provides connection and helps the patient stay with her/his feelings. Body language such as slumped shoulders, downward gaze, or restless hands conveys patients’ reactions more clearly than words.

- Patients’ off-hand comments such as, “Oh well, that’s the way things go for me,” or a change of topic, are clues to their feelings. Invite them to elaborate on such responses. If the silence continues, ask something like, “I wonder what feelings or thoughts you are having in response to this news?” Occasional patients will not want to talk about termination, and your respecting this choice and patients’ boundaries is appropriate. You can reassure patients of your continued willingness to talk, that all emotional responses are acceptable and that you will help them plan for the future.

- Offer relationship building empathic statement (described above and in Modules 6 and 13)

AnnotatedVideo (not shown in print-out text)

---

**PHYSICIAN RESPONSES TO TERMINATION**

Clinicians should mindfully attend to their own feelings about saying good bye and cultivate awareness that both their medical decisions and their responses to patients are influenced by those feelings.

NOTE: move appdx 1, with an intro sentence, into this section......

The truism that “doctors have feelings too” is underscored when clinicians say good bye to
patients. Degree of comfort with emotional and interpersonal issues, attachments to particular patients and conflicts with others influence clinicians’ responses. Sadness is to be expected but guilt, anger and relief are equally common (Dr. W in Case 4.). Cool or noncommittal patient reactions can wound the clinicians’ self-esteem, particularly for residents just establishing their professional identity. Increased cynicism is an unfortunate result that can be minimized through reflection and discussion (Case 5. below).

Reflection and personal awareness are key attributes that support clinician resilience and effectiveness during times of relationship stress (Module 2). Saying good-bye to a large number of patients is always daunting, and even more so if leaving the practice entails additional administrative burdens (Dr. W. in Case 4). Clinicians may intensify their medical focus and worry that they missed diagnoses or neglected preventive measures. Adding this concern to the prospect of multiple emotional interchanges may provoke clinicians to procrastinate.

Table 1: Difficult Emotional Responses to Termination of the Doctor-Patient Relationship

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Sadness</td>
</tr>
<tr>
<td>Anger</td>
<td>Anger</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>Guilt</td>
</tr>
<tr>
<td>Feeling abandoned</td>
<td>Relief</td>
</tr>
<tr>
<td>Diminishing self esteem</td>
<td>Emotional Fatigue</td>
</tr>
<tr>
<td>Denial</td>
<td>Denial</td>
</tr>
<tr>
<td>Discomfort with ambivalent/negative feelings</td>
<td>Discomfort with ambivalent/negative feelings</td>
</tr>
<tr>
<td>Disillusionment with medical care and doctors</td>
<td>Cynicism about lack of patient appreciation</td>
</tr>
<tr>
<td>Uncertainty about future care</td>
<td>Embarrassment about patients' gifts</td>
</tr>
<tr>
<td>Anxiety that important medical information will be lost in the transition</td>
<td>Anxiety about how medical care will be judged by incoming clinician</td>
</tr>
</tbody>
</table>

Table 2: Behavioral Responses to Termination of the Doctor-Patient Relationship

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>DOCTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed appointments</td>
<td>Not returning calls</td>
</tr>
<tr>
<td>Decreased adherence</td>
<td>Failure to inform patients about leaving</td>
</tr>
<tr>
<td>Increased somatic complaints</td>
<td>Hurried attempts to complete work-ups</td>
</tr>
<tr>
<td>Difficult bonding to new doctor</td>
<td>Avoidance of emotional issues during interview</td>
</tr>
<tr>
<td>Giving gifts</td>
<td>Over/under involvement</td>
</tr>
</tbody>
</table>

Boundary issues in transfer of care
Patients may bring gifts of appreciation and may want to hug and kiss the doctor. As a rule, receive these signs of patient affection and gratitude with warm appreciation. A brief and gracious relaxation of the usual boundaries of the professional relationship is almost always appropriate.

When saying good-bye to patients it is appropriate to express your own feelings of sadness and to let patients know you will miss them.

**TIME-LIMITED SETTINGS**

Relationships are predictably time limited in settings such as residency clinics, subspecialty consultative practices, inpatient coverage schedules for teaching attendings and for hospitalists.

The practice setting strongly influences the emotional and behavioral aspects of clinicians’ departures. In many settings, short-lived relationships are the rule. Patients may quickly develop intense bonds with hospital-based clinicians (hospitalists), sub specialists and other personnel such as nurses and physical therapists. Hand-offs of care at shift change are mini-terminations. Preparing patients for changes in clinician coverage. Responding empathically to patients’ reactions improves relationships and probably enhances both quality of care and patient satisfaction.

**Resident continuity practices**

Residents in continuity clinics benefit from structured reflection on transfers. In their own ways, many patients learn to anticipate the changes.

**Case 5:** After a workshop on terminations and transfers of care, a medicine resident scheduled to complete training in 3 months tells a clinic patient that he will be leaving the practice soon. Afterwards, he meets with his clinic attending.

**Attending:** “So, how did the visit go?”

**Resident:** "Not too well."

**Attending:** "I'm sorry. What happened?"

**Resident:** “I said I was leaving and she just said, ‘Oh, I expected that. Everyone knows that residents leave every three years.’ She didn’t seem bothered at all.”

**Attending:** “How do you feel about her reaction?”

**Resident:** "Well, it just shows that we residents are interchangeable. Patients seldom appreciate all that we do for them. I don’t think I’ve made much of an impact."

This resident’s response carries a tone of disillusionment and a tinge of cynicism, as is common in this situation. Workshops on departures and transfers of care provide opportunities for residents to reflect on and learn from these and other responses.

Residents and their patients frequently form meaningful and intense connections despite the limited duration of their relationship. However, most patients in resident clinics weather terminations without impairing their care, perhaps reflecting resident and clinic efforts to inform patients and insure smooth transfer of care. Quality improvement experts point out that planned
and purposeful communication during care transitions increases patient safety. Furthermore, patients who understand that clinicians change at least every three years may form a bond to the clinic rather than to the doctor, what Reider called “institutional transference”.

However, some groups of patients have an increased risk of disruptions in care – including those with complex medical conditions, challenging psychosocial circumstances, non-adherence and frequent in-patient or ED visits. Practice based processes to prospectively identify patients at high risk and provide structured handoffs can reduce the number of patients lost to follow-up or who show up for care in the emergency department or acute care clinic post handoff.

**Brief and intense relationships**

Clinicians and patients bond quickly when patients are suddenly stricken, hospitalized or very concerned about their illness. In many settings, these intense bonds are soon broken and patients are “left” frequently, as specialists arrive and leave, at shift changes or while traveling.

**Office Practice:**

**Case 6:** Mr. R developed painful corneal erosions on a Friday afternoon while at a remote conference center. Initially very concerned, he was pleased and reassured by the evaluation done by Dr. O, an ophthalmologist nearby. Before leaving the office, Mr. R. asked what he should do if pain recurred or his vision worsened.

**Dr. O:** “My partner is on call this weekend. I’ll bring him down to meet you and take a look at your eye. That way you’ll have already met each other if a problem arises and he’ll know what your eye looks like today. How does that sound?”

**Mr. R:** “That’s perfect. What a relief!”

Despite the brevity of their encounter, Mr. R. and Dr. O established a clinician-patient relationship. Dr. O. recognized that to insure quality of care and to address Mr. R’s concern, it was important to introduce the patient to the clinician on call.

**Hospital Practice:**

Hospitalist clinicians often form intense yet time-limited connections with their patients. At shift changes, hand-offs are mini-terminations as well as the medium for information exchange. At a minimum, patients appreciate being informed prior to an upcoming change in attending clinician. Bedside hand-offs have the advantage of providing an opportunity to say “good-bye” and introduce the new clinician.

AnnotatedVideo (not shown in print-out text)

**POSITIVE POTENTIAL OF CARE TRANSFER**

Separation presents an opportunity to review important events and savor the value and meaning of the relationship. Physician and patient may both acknowledge mutual affection, respect and caring.

Near the time of transfer, patient and doctor can review the “ups and downs” of their work
together; and talk about times that have been challenging or difficult as well as those that have been successful and rewarding. Issues of trust and feelings of abandonment warrant explicit discussion. The patient’s personal strengths, contributions, resources, and social supports can be emphasized, and termination can stimulate valuable growth and enhance the patient’s sense of self-efficacy. The review often highlights personal and community resources for self-management, critical elements in the management of chronic illness. Patients can also reflect on what they value most in a doctor and consider these factors as they choose a new clinician.

The opportunity for review should not be missed or discounted. Despite social and institutional forces that conspire against spending time in “reviewing relationships”, a few minutes spent on communication at a personal level improves self-awareness, promotes personal growth, builds community and broadens clinicians’ abilities to manage complex, novel and unanticipated future relationships and situations.

### Choosing to Dismiss

Rarely and as a last resort clinicians may decide to dismiss a patient or a patient may request transfer to a new clinician. The behaviors and emotions that provoke these decisions can sometimes contribute to improving a relationship, or at times cause irretrievable deterioration of the relationship.

Dismissals are typically considered for patients characterized as “difficult”, “hateful” or “heart sink.” Such labels typically arise in the following situations:

- repeated infringement of relationship boundaries,
- disruptive or threatening behaviors,
- a degree of continuous non-adherence that makes reasonable management impossible and is a risk to self and a liability to others, or
- strongly negative emotional responses that clinicians think will significantly cloud professional judgment.

In the past, patients who repeatedly presented medically unexplained symptoms (MUS) were often labeled in this negative fashion. With improved understanding of somatoform disorders, and formulation and descriptions of effective communication and treatment strategies, this problem is diminishing. (Module 31)

Management problems related to prescription of opioid medications for chronic pain are worsening, and too many relationship problems now result in dismissal of patients with chronic pain problems. (see below).

A written policy on patient dismissal helps ensure that each situation is handled with strict adherence to medical, legal and ethical guidelines.

### Chronic pain

Clinician and patient uncertainty and concerns about management of pain with opioid medications interfere with maintenance of mutual trust and respect..

Prescriptions for opioid analgesics are a frequent cause of breakdown and termination of the
clinician-patient relationship. Difficulties often center on a patient's view that the clinician is unfairly withholding pain relief while the clinician views the suffering and needy patient as drug seeking and manipulative. The relationship dynamics are worsened because indeed some patients skillfully play the suffering and needy role as part of their substance abuse problem. (Module 30)

**Case 8,** Patient view: Ms. B frequently visited her PCP complaining of severe and unrelenting back pain. Despite non-diagnostic imaging studies, Ms. B insisted that her pain was "real" and required escalating dosages of opioid analgesia which her clinician declined to prescribe. She felt her clinician underestimated her suffering, did not understand the importance of pain relief in allowing her to continue working as a potter and increasingly viewed him as cold and unfeeling. After several frustrating months she contacted the clinic director requesting a new PCP.

Clinician view: Dr. M. came to dread seeing Ms. B. because her visits were dominated by demands for opioid analgesia. Although he cared deeply for Ms. B’s well being he was increasingly convinced that she was abusing pain medications and might even be obtaining narcotics "on the street" which she vehemently denied. Dr. M asked the clinic director to assign Ms. B another PCP.

**Suggestions for practice:**
The relationship breakdown between Ms. B and Dr. M might have been prevented by establishing a formal treatment agreement prior to starting a regimen of chronic opioid therapy. An opioid agreement delineates patient and clinician responsibilities for the conduct of treatment and specifies consequences if these responsibilities are not met. The efficacy of treatment agreements (often labeled opioid or narcotic “contracts,” although they lack the legal status of a formal contract) has not been established, but clinical experience suggests they set a tone of shared decision making, and define boundaries that help sustain respect and trust (see Module 30 video, “narcotic contract,” and “resistant patients”).

Clinicians may decline requests to prescribe opioids, but continue to offer alternate approaches to pain management that will improve function, and continue to care for a patient’s other medical problems.

"I appreciate that you are in pain and I am committed to providing you the best and safest medical care. In my opinion, opioid analgesics are not (or are no longer) an appropriate management approach to your pain and I do not plan on prescribing them. I know this is disappointing news for you and may not be what you hoped for. If you would like, I will refer you to a pain specialist for another opinion on management. I also want you to know that I am willing to continue to be your PCP and work with you on your other health issues."

**Reconcile or dismiss?**

Establish practice guidelines for dismissal; make relationship deterioration an explicit discussion topic, and consider the pros and cons of reconciliation versus dismissal. Patients sometimes dismiss a clinician, as well.

When a relationship is deteriorating clinicians should initiate conversations about the decline and adhere to principles outlined in prior modules regarding difficult conversations. Reconciliation can result in a strengthened partnership, whereas dismissal of a patient leaves a bad taste for both parties – and often for other staff as well. To begin, respectfully describe the behaviors that cause serious concern and ask for the patient’s point of view. Elicit the patient’s goals and values, and do not focus on entrenched positions – maintain a nonjudgmental stance. Avoid arguments, counter-attacks and defensiveness. As in all relationships, negotiation is more likely to succeed if the clinician raises concerns before they reach the “difficult”, “hateful” or “heart sink” level of
Clinicians should write and honor practice-specific guidelines for dismissing patients, and review them prior to taking action. Initially it is prudent and helpful to review concerns and decisions with trusted colleagues, and to enlist support from practice managers, risk management, patient advocates and/or a patient relations office.

Depending on the setting, the intensity of the conflict and the participants’ tolerance for negotiation, the benefits of a fresh start with a new clinician may outweigh those of continued attempts at reconciliation. Outright threats to the clinician or the practice are particularly intolerable. The personal challenge of skillfully responding to the strong emotions engendered is addressed in other modules.

**Dismissal may also be initiated by a patient who is dissatisfied with care and requests a new doctor.**

*Frequently cited reasons for dismissing clinicians are behavior that is dehumanizing, rude, uncaring, impersonal, unresponsive, incompetent, dishonest, or belligerent.*

A patient’s request for transfer presents an opportunity to reassess goals, values and boundaries and potentially discover mutually acceptable approaches to better communication, better relationship and better care.

---

**DEATH OF A PATIENT**

Death is a special instance of leave taking, and an opportunity to extend compassion to the family; a meaningful letter of condolence may produce important benefits for the bereaved.

Death of a patient means saying good-bye to the patient and in many cases acknowledging and responding to bonds with the patient’s family. Attending the patient’s funeral or visitation acknowledges the patient’s value and is an opportunity to grieve the loss. Sharing feelings and memories with the family or colleagues facilitates the mourning process and comforts both family and clinician.

**Case 7: Mr. E, 33, died on a general medicine unit from complications of chronic hemodialysis. The attending clinician wrote to the family expressing his condolences and availability. Several weeks later the patient’s sister requested an appointment and described overwhelming grief and guilt since her brother's death. "If only I had donated my kidney he would still be alive.” After responding to her grief, the clinician reminded her that her brother was not deemed an acceptable transplant candidate. He scheduled a meeting with the nephrologist, who answered her questions and further relieved her guilt**

A letter of condolence communicates personal involvement, human connection and availability. It extends compassion to the patient’s family. If there is no communication, families may wonder, "Where did the doctors go?" In case 7, the clinician’s extension of caring and availability provided relief, and may have prevented an extended bereavement response or depression. Bereaved survivors, especially a spouse, suffer increased morbidity and mortality after a loss. Increased attention to the emotional, social and medical needs of the bereaved may mitigate the risk.

**Practice suggestions for a Letter of Condolence**

- Acknowledge the loss and name the deceased
- Express your sympathy
- Note special qualities of the deceased
- Recall a memory about the deceased
DEPARTURE FROM PRACTICE: ETHICS

Planning for terminations and transfers includes meeting specific ethical obligations and a careful review of a clinician’s patient panel to identify patients especially vulnerable to disruptions in care.

Departures from or closing a medical practice increase the workload and are emotional and stressful times for practitioners, staff, patients, and others. If mishandled, terminations can significantly disrupt continuity of care as well as office routines and efficiency. Clinicians should facilitate teamwork with practice managers, nursing and support staff that will allow everyone to contribute to smoother transitions. Forethought and planning prevents discontinuity and disruption and improves patient satisfaction.

Clinicians who leave a practice must attend to the following ethical obligations:

- Inform patients of major changes (such as the clinician leaving the practice).
- Notify patients sufficiently in advance (at least 30 days) to secure other medical care.
- Inform patients how to contact the departing practitioner.
- Facilitate patients’ ability to choose a practitioner from among those in the practice or outside, within existing constraints.
- Tell patients how to obtain copies of or transfer of their medical records.

In settings such as resident clinics where turnover is predictable, patients should be informed early that their clinician will leave when training is finished. Planning for terminations and transfers includes meeting specific ethical obligations and a careful review of a clinician’s patient panel to identify patients especially vulnerable to disruptions in care. Patients requiring special attention and planning for social, psychological or medical reasons should be identified early. Advance planning is necessary for patients with complex illness and chronic diseases. Vulnerable patients should be contacted and encouraged to schedule an appointment prior to the clinician’s leaving. Give special consideration in choosing a new clinician for patients with limited English language skills or other cultural preferences. Patients without a scheduled appointment and not at special risk for separation problems can be informed of the practitioner’s leaving by phone call or letter. (Appendix). The letter should fulfill the obligations listed above.

Office personnel can provide a sense of continuity in clinics where clinician turnover is high. In resident clinics, attending clinicians can help smooth transitions in care.

- Provide the patient with (or direct them to) information regarding transfer of medical records and other logistic matters.
- A patient’s new clinician should be identified by name and introduced to the patient, when possible. A personal meeting of outgoing and new clinicians allows the sharing of information, especially about interpersonal issues or others that might result from the transfer of care that even the best transfer note cannot adequately convey.

Appendix

Dear Mr./Ms. Patient:

I will be leaving the ___name of practice___ on ____date____. Thus, I will no longer be able to
serve as your clinician. I am writing because I want you to be aware that I am leaving and to allow enough time for you to make an appointment with me, if you wish, before I leave. My colleagues at __name of practice__ have agreed to take on your care. Each one is a dedicated and caring clinician. Some patients have already made plans to see one of my colleagues. If you have not done so, you should call and make an appointment with a new doctor. When you call, our office staff will tell you whether the clinician you prefer is available. I know you will receive excellent care. If you wish to transfer your care to another practice, our office can provide a list of clinicians and you should sign a release for your medical records.

I also want to take this opportunity to tell you something about myself and the reasons I will be leaving the practice. (insert message)

I will miss you and will carry you in my heart. Being your clinician has been a tremendous privilege. With this note I am sending you my best wishes for a healthy and meaningful life.

Sincerely yours,

---

**RELEVANT BEHAVIORS**

- Initiate termination conversations with sufficient lead time
- Address termination early in the interview, and make a simple, clear statement that you are leaving
- Explore patients’ perspectives and feelings about the separation
- Dialogue with your patients about your relationship, value their contributions to their care, their autonomy and resources
- Acknowledge your own feelings - openly or privately as appropriate to situation
- Involve practice staff and colleagues in preparing for transfers of care
- Assess vulnerability and special needs of selected patients
- Identify new clinician by name and arrange a brief personal meeting
- When seeing new patients, inquire about their relationship with prior clinicians
- When relationships begin to deteriorate, initiate early discussion of relationship problems
- Dismiss patients with insurmountable doctor-patient relationship problems
- When patients die, extend compassion to the family

---

**LITERATURE REFERENCES**

1. Pincavage A, Prochaska M, Dahstrom M, et. al. Patient safety outcomes after two years of an


Welcome to DocCom Module 37:
"Oral Presentation"

by Alicia D. Monroe, MD, and others
Rationale
Alicia D. Monroe, M.D.

The Students' View

The Mentor's View
Alicia D. Monroe, M.D.

Questions for Reflection:

1. Think of a case presented to you that was difficult to follow. What caused the difficulties?
2. Think of a case presented to you so well that the justifications for the assessment were clear to you before the presenter even got to that section. Why?
3. What aspects of your own oral case presentations would you like to improve?

Key Principles:

1. Using a standard format can guide novice and advanced learners in organizing essential information for oral case presentations
2. Determining and adjusting to the expectations of your audience and setting can guide learners in tailoring oral case presentations
3. Attending to your presentation style (e.g., appearance, demeanor, and verbal and nonverbal signals) can enhance the quality of oral case presentation
4. Advancing students use clinical reasoning to prioritize and organize oral presentation content
5. Practicing your oral case presentation can enhance fluency, confidence and competence
6. Asking for feedback on oral case presentations can support skill development

Learning goals:
At the conclusion of this module, you will be able to:

- Value learning and mastering the skills required to organize and deliver effective oral presentations
- List key principles for constructing effective oral case presentations, and list common problems that interfere with effectiveness
- Use the STAGE framework to tailor oral case presentations so that they meet clinical and educational goals
- Appreciatively ask for, receive and deliver feedback about your own and colleagues’ skills at making oral presentations

INTRODUCTION

Oral case presentation is a distinct clinical skill, and this module provides engaging tools and a cognitive framework (STAGE) to assist with learning and improving this skill.

STAGE is a mnemonic for a framework that guides learners in developing their oral case presentation skills, and also guides faculty in providing feedback to learners. Teachers and learners can utilize the STAGE framework to review key elements of oral case presentations, to model or practice delivering them and to give or request feedback on presentations.

Check out the video example where Dr. Monroe describes the goals of this module.

This module advocates for augmenting instruction in oral case presentation, and reviews key concepts and the STAGE framework, through text, video and exercises.

OVERVIEW

Advancing students master the primary components of oral case presentation: structure/content and style of delivery.

Students who master the novice level can extract key information from the patient’s narrative, organize information chronologically, and use a structured presentation style. Effective novices are able connect the facts into a chronological, relevant and condensed medical narrative.

More advanced learners understand what listeners typically need in order to engage quickly with
unique features of a case, to rapidly understand the clinical issues and to construct a differential diagnosis. The advanced presenter uses this understanding to filter, sort and organize the data so as to deliver a succinct, organized, compelling and engaging presentation. As an advocate for the highest quality of care for the patient, the presenter wishes to provide listeners with essential facts so as to achieve the best possible outcome. The advocate’s central task is to organize data from several domains, including a) the patient’s current symptoms and story, b) relevant psychosocial and behavioral factors, c) important physical findings, d) and relevant laboratory, radiology and other data. Advanced presenters balance the need for thoroughness against the helpfulness of succinctness, and omit details that might be interesting, but not relevant to the patient’s central issues.

**Similarities and differences between written and oral presentations**

While both types of presentations document the relevant data to support diagnosis and treatment, there are important differences. The written writeup is comprehensive while the oral presentation is focused and concise.

Written and oral presentations each thoughtfully organize the patient’s narrative into a coherent and sequential HPI and utilize the same format and information. The information includes subjective data elicited from the patient, family and records, and objective data from physical exam, laboratory and radiology. The written record is more expansive about narrative details and symptoms, and also more thoroughly describes past problems, potential future problems, psychosocial details, review of systems and comprehensive physical and laboratory exams.

**Basic principles for oral case presentations**

The oral case presentation is a brief edited presentation of the essential information using a standard approach. However, it is not uniform, and its content depends on audience, setting and goals. Use notes and practice at first, so as to develop proficiency and efficiency in this aspect of clinical care and clinical education.

Not only do oral presentations differ from written, but the length and amount of detail are influenced by the audience and setting (medicine attending rounds, a surgery consult request, obstetrics and gynecology walk rounds, pediatrics evening sign out), and the goals of the oral presentation (teaching, patient care and/or evaluation of clinical skills). A full medicine presentation in attending rounds should be under 5 minutes. A presentation in the hallway on walk rounds on surgery should take no more than 1-3 minutes. Students are often uncertain what is expected, and so should check with supervisors to clarify expectations.

**Check out the video example** about the importance of practice
Students’ initial oral presentations should be written, practiced and then delivered with minimal dependence on written notes. Advanced students will be sufficiently familiar with varied formats and sufficiently engaged with the details and management of their patients that they will eventually not need notes to organize and concisely present appropriate essential details.

**Standard format for the oral case presentations**

Novice medical students focus on the seven basic components of the standard case presentation, which form the STORY of the presentation. Advanced students add an eighth component, the Plan for the primary problem plus an Assessment and Plan for additional active problems.

As your basic science, physical exam skills and clinical problem-solving skills increase, the requirements of your oral case presentations will also grow. You will expand the formulation section of the case presentation to include the differential diagnosis and a plan for evaluation and treatment.

![Check out the video example about format and content expectations for novice and advanced learners](image)

1. The Opening Statement (Identifying information/chief complaint ID/CC)
2. The History of Present Illness (HPI) including relevant information from Review of Systems (ROS—these include symptoms related to the major and adjacent organ systems, constitutional complaints such as fever and weight loss and epidemiological risk factors or exposures)
3. Other active medical problems
4. Selected Elements of Past Medical History
   - Selected Hospitalizations/surgeries (relevant to HPI)
   - Medications/OTC/Herbal remedies
   - Allergies (reaction)
5. Brief Social History (current situation and major issues only and tobacco, alcohol and substance use)
6. Physical exam (pertinent findings only)
7. Formulation/Summary statement of the primary problem (includes differential diagnosis)
8. Plan for primary problem and Assessment/Plan for each additional active problem (for advanced level)

Advanced presenters use clinical reasoning to guide the structure and content of oral case presentation, organizing and prioritizing information based on what you think are the patient’s most likely diagnoses.

**STAGE FRAMEWORK FOR DEVELOPING EFFECTIVE ORAL CASE PRESENTATIONS**
STAGE is a structure that incorporates the standard format for oral case presentations with tips for guiding you in creating and tailoring your oral case presentations.

The elements of STAGE include: Story/Style, Timing, Audience, Goals, and Eliciting Feedback.

Check out the video example where Dr. Monroe names and describes the elements of oral case presentations.

The sections below provide additional annotations and guidance for creating and tailoring oral case presentations.

---

**STORY**

The first element includes both the Story and Style.

The Story contains the standard seven or eight components listed below.

1. **Opening Statement** (Identifying Information/Pertinent Illnesses/Chief Complaint)
2. **History of Present Illness** (HPI)
3. **Other Active Medical Problems**
4. **Past Medical History** (PMH)
5. **Social History**
6. **Physical Exam**
7. **Formulation/Summary statement** of the primary problem
8. **Plan for primary problem** and Assessment/Plan for each additional active problem (for advanced level)

---

**Opening Statement (Identifying Information/Pertinent Illnesses/Chief Complaint)**

This element is the Story headline and engages the listener, states the presenting problem, and introduces the patient as a person.

The identifying information includes the patient’s name, age and -sex (gender is a social construct that relates to how one defines one’s role and identity in society, sex connotes biology only and is the preferred term—this explanation is not for inclusion in the paper), and the presenting complaint in his/her own words, with the apparent duration of the complaint. At times it states other past or active medical problems relevant to the main problem—and if so, lists them only by diagnosis, as the “HPI” or “other medical problems” elements provide more details. Ask for help in deciding whether to state other active problems when this is not obvious.
Do not include race or ethnicity unless it helps listeners weigh diagnostic possibilities differently.

Avoid editorial comments and distracting information—in particular, do not give any detail about other medical problems.

Check out the video example about content of opening statement including CC

Contrasting Examples:
(Providing editorial comment and too much detail): Mr. Jones is a difficult but unfortunate 35 year old man with a complicated social history, his active problems include diabetes mellitus complicated by retinopathy and nephropathy, COPD with FEV1 of 1.5 liters, coronary artery disease with EF 50%, who presents with a chief complaint of abdominal pain for 3 days after going on a drinking binge.

(Improved): Mr. Jones is a 35 year old who presents with abdominal pain for 3 days following one week of heavy drinking. His active problems include diabetes mellitus, COPD and CAD.

Listeners will be distracted by the interesting comments and details in the initial example. The improved example does not interrupt listeners train of thought between the chief complaint and the history of present illness. Relevant information about the problems might be stated in the “HPI” or “other medical problems.”

Additional Good Examples:
Mr. Mason is a 47 year-old man with a 10 year history of diabetes mellitus who presents with a chief complaint of nausea and vomiting for 3 days.

Mrs. Hernandez is a 50 year-old woman who was electively admitted for evaluation of increasing shortness of breath over 5 days. Her active problems include sarcoidosis and hypertension.

Mr. Jones is a 22 year old man who comes to the clinic for follow-up of daily headaches.

---

**History of Present Illness (HPI)**

The HPI element begins with a general statement of the patient’s health prior to onset of the current illness then tells a chronological story that includes details about the important symptoms.

Begin the HPI with an introductory statement of prior health/function, and follow this with a chronological reporting of the illness story. This introductory sentence typically follows the following format:

*Mr./Mrs./Ms.____ was in his/her usual state of (excellent health/poor health) until (three days/weeks) prior to admission when she (suddenly/gradually) developed (pain/fever/wheezing).*
State times relative to admission (e.g., 3 days prior to admission), instead of reporting that an event occurred “on Saturday”.

**Check out the video example** where Dr. Monroe demonstrates HPI

**Good Examples:**

Mr. Boone has a long history of chronic obstructive lung disease and home oxygen therapy. He was in his usual state of health until three days prior to admission, when he developed gradual worsening of his shortness of breath, associated with a cough productive of yellow sputum and a fever of 102.

Mr. Ryan has a long history of coronary artery disease including three myocardial infarctions, the most recent in 2004, and congestive heart failure. He was in his usual state of health, with angina occurring once per week, until the night of admission when, while watching a football game on television, he suddenly developed severe substernal chest heaviness.

In the HPI, characterize the major presenting symptoms, state what the patient thinks is causing the symptoms (his attribution), and mention any prior episodes, complications and the relevant Review of Systems (ROS) questions (include both pertinent positives and negatives). If there was any evaluation of the chief complaint prior to hospital admission, include this also.

A useful memory aid to help characterize symptoms is **OPQRST + Associated symptoms:** Onset, Provocation/Palliation, Quality, Radiation, Site/Severity, Temporal features—Timing including constancy, duration, frequency, changes over time (progressive, stable or improving); previous similar episodes; + what else happened- for example, if the major symptom is wheezing, describe associated cough, pain, fever, rash, and so on..

Give relevant Past Medical History, Social History, Family History contributing to HPI. The positives and negatives from Review of Systems are usually pertinent to the differential diagnosis.

**Contrasting HPI examples:**

(poorly characterized and too brief)

...admitted for evaluation of chest pain. He was well until three weeks prior to admission when he began to feel chest heaviness whenever he exerted himself. He saw his local doctor who prescribed antacids with little benefit. The pain woke him last night so he came into the emergency room for evaluation. His other problems include.......

(symptoms characterized and relevant past history, family history, ROS and other details added)

...admitted for evaluation of chest pain. He was in his usual state of good health until one week prior to admission when he developed the gradual onset of intermittent chest pain, characterized as substernal heaviness which radiated to his jaw and left arm, lasting about five minutes per episode, occurring several times a day, aggravated by exertion and relieved by rest. Associated with the pain were shortness of breath and sweating, but no nausea. One week prior to admission he was seen by a local doctor who, without other testing, diagnosed
gastritis and prescribed antacids without benefit. The chest pain was stable until two hours prior to admission, when the patient awoke with a more severe version of the same pain that lasted until he came to the emergency room. He was quickly transferred to the coronary care unit. There was no history of cough, heartburn, weight loss, fever, or chills. The patient has a positive family history coronary artery disease, a cholesterol of 310 in 1998, and has never smoked cigarettes.

Other Active Medical Problems

Learning which problems to state in an oral presentation, learning the “key words” that apply to describing different illnesses, and learning what is “irrelevant” for a particular oral presentation is complex, and must be learned in the context of active participation with more experienced clinicians.

Other active problems include the same problems mentioned in “Opening statement”. For example, diabetes mellitus is relevant for a patient admitted with angina. Consider each condition separately and recount details chronologically; for example, first explain the history of coronary disease, telling the story from the beginning to the present, then discuss his peptic ulcer, and then his COPD. Present information on a series of problems in order of importance, with most important first.

...his other medical problems include insulin-requiring diabetes for 12 years and complicated by retinopathy, painful polyneuropathy, and nephropathy. His recent creatinine was 1.7.....

Use “key words” and phrases to summarize an ongoing chronic illness in this section. In general, key words emphasize date of diagnosis, its treatment, current symptoms, complications, and recent objective tests. Appropriate “key words” vary with the nature of the problem, and you learn these with clinical experience and by listening to more experienced clinicians make oral presentations.

.....history of multiple abdominal procedures including appendectomy, cholecystectomy and hysterectomy, and insulin dependant diabetes with target organ dysfunction....

.....long history of chronic obstructive lung disease with steroid dependence and the requirement for home oxygen therapy, a 1994 FEV1 of 0.8L, and three hospital admissions for exacerbations in the last year. He has never been intubated...

...two year history of congestive heart failure, felt to be secondary to alcohol cardiomyopathy, characterized by chronic one block dyspnea on exertion, three pillow orthopnea, and ankle edema. In addition to his long term therapy with furosemide and enalapril, digoxin was added six months ago. An echocardiogram four months prior to admission showed four chamber enlargement and global hypokinesis with ejection fraction of 35%......

Avoid presentation of “irrelevant” diagnoses. Like “key words” what is “irrelevant” is seldom obvious to novices. For example, “syphilis in 1940, malaria in 1952, cataract extraction in 1972, and cholecystectomy in 1987” are usually irrelevant during presentation of the patient with diabetes and crescendo angina.

Past Medical History (PMH)

Include all of the patient’s problems in your write-up, but refrain from orally presenting
problems not relevant to the current active problems.

Select which hospitalizations and surgeries to include. List all prescribed medications (have information on dosages available), and any relevant non-prescription medications and herbal medications. Of course, you will only be able to give as much detail about medications as the patient can give you, unless you have the patient's chart or office medication list. Report any drug allergies and the type of reaction (for example, “...developed a rash after receiving penicillin 20 years ago and carries the diagnosis of penicillin allergy”).

---

**Social History (current situation and major issues)**

Every person has a complex social history; summarize it in a brief paragraph (2-3 sentences).

The social history often explains why the patient has fallen ill or decided to seek care now. For example, patients may lack social support and the help needed to follow plans, few financial resources to buy medications, or depression that retards their taking action. If unaddressed, these factors lead to hospitalizations.

Comment on current life situation including habits, work, living environment, and support systems, and important stressors.

Include information about advance directives (living will and durable power of attorney) and any discussion with you about these issues. Summarize substance use, but if mentioned in the HPI, do not repeat it. Include tobacco, alcohol and other drugs (including abuse of prescribed drugs). State amounts, frequency, and duration; and include intravenous use, past or present.

Relevant information regarding Family History and Review of Systems has usually been incorporated into other elements of the Story.

---

**Physical Examination**

Report of physical examination findings always includes a general description, vital signs and both positive and negative findings pertinent to the admitting problem and active diseases.

*Check out the video example* where Dr. Monroe demonstrates report of PE

This aspect of oral presentations includes several elements. Begin with a general description – paint a word picture so listeners can visualize the patient. “The patient was sitting on the edge of the bed, leaning forward and gasping for breath” is better than “the patient was short of breath.” Always state the vital signs, and mention relevant postural changes in blood pressure and pulse.
After the word picture and the vital signs, limit presentation to relevant positive findings and relevant negative findings. An example of ‘negative findings” in the dyspneic patient would be that “the exam is remarkable for clear lungs bilaterally.” Use concise but complete descriptions of positive findings.

Formulation/Summary statement of the primary problem (includes differential diagnosis)

The formulation synthesizes pertinent data into a problem title from which the differential diagnosis is derived.

This synthesis takes the following form: “…the patient’s presenting problem is wheezing/abdominal pain/urethral discharge. Then state “The differential diagnosis includes a/b/c. The diagnosis of c appears to be most likely because of x, y, and z.”

…..the patient’s main problem is a crescendo pattern of exertional chest pain, now prolonged at rest, which could be due to a myocardial infarction, a dissecting aortic aneurysm, pericarditis, and other diagnoses such as pneumonia, pulmonary embolus, or esophageal disease. MI seems most likely, because his description of chest pain is classic for angina and because his ECG reveals a new injury current in the inferior leads.

Plan for primary problem and Assessment/Plan for each additional active problem (for advanced level)

As you advance, your presentation will include specific plans for confirming a diagnosis, instituting treatment for it and monitoring the progress of the illness. For each active problem, you will present an assessment, including differential diagnosis (if diagnosis not known) and plan.

…..to diagnose the MI, I recommend a cardiac enzyme panel and repeat ECG in the morning. We have ordered ASA, B-blocker, ACEI, a statin and consulted cardiology for consideration of angiography and intervention. The patient is on continuous ECG monitor and frequent vitals. In addition, the uncomplicated diabetes is well controlled on insulin. The hypokalemia is probably due to chronic use of diuretics but may be induced by the stress of this acute illness. Replacement potassium has been ordered along with a repeat blood test....

STYLE

Style, which includes appearance, demeanor and nonverbal signals, strongly impacts the quality of your oral case presentation.

- Modulate your voice and cadence of your presentation. Every patient is unique; capture the special elements so as to engage the listeners. Paint a word picture of the patient.
- Stand up straight and make eye contact so as to connect with listeners.
- Do not bury your nose in the chart; and do not read verbatim your presentation.
- Become enthusiastic about this patient, and show your engagement with the situation.
Rehearse and know the situation well enough to feel confident and show it. In the case of inadequate time for preparation, say so, only once, and be confident about what you do know. “Sweating bullets” severely limits your learning and that of others.

- Avoid distracting “Um’s/Ah’s” during your presentation- silent pauses are always preferable to “um’s”
- No one likes to listen to repeated nonsense syllables or fillers, such as, “ok”, “maybe”, or “the patient said that...” Eliminate verbal “tics” from your repertoire.
- Learn from colleagues, attend to presenters who engage you and make the exercises fun, then imitate them. Think of a sport, or a jazz ensemble.

**TIMING**

Timing is influenced by expectations specific to the setting of your oral case presentation.

Specific courses, clinical settings, and supervising residents or attendings impose differing expectations for the duration of a presentation. Ask supervisors and instructors about their expectations and preferences for length, conciseness, and when they prefer summary versus details. Observe your colleagues.

Mostly people want to help learners. Complex medical issues, busy clinical services and other demands on your instructors may require your attentiveness and may influence the timing of your presentation.

**AUDIENCE/SETTING**

Presentations typically occur in the conference room, hallway or bedside. Each audience and location requires adjustments to your presentation.

*Check out the video example* about seeking clarification of audience/setting

Bedside presentations require attention to the patient and family and usually include an invitation to them to add to or edit the information in your presentation. While bedside presentations may seem difficult or awkward, studies confirm strong patient preference for them and, with practice, growing learner preference, too. Following a bedside presentation, it is important for you to check with the patient in order to clarify or resolve any questions related to your presentation. Make additional adjustments related to special audiences (grand rounds versus daily work rounds), to the degree of privacy available, and to how well listeners already know the patient.
GOALS

The specific goals of a presentation determine the details of content, length, and organization.

Common situations that call for important alterations in oral presentation include arranging cross coverage, informing the team of new admissions, and formative or summative evaluation of learner skills. Consider whether the goal is to promote patient safety and high quality patient care, to promote group learning, or to perform for an evaluation of your knowledge and skill.

Elicit Feedback

Feedback on presentations enables you to obtain information from different observers, utilize ideas derived from multiple perspectives, make targeted adjustments, and check on whether you are advancing your skills.

Check out the video where Dr. Monroe reinforces reasons for eliciting feedback

Feedback provides important information about how to adapt your approach in the future. More feedback is better than less, and immediate feedback is preferable to feedback that is delayed. The following strategies can assist in structuring and organizing feedback.

- Self-assess each component of your presentation in light of the STAGE framework.
- In advance of a presentation, establish your colleagues’ (and faculty) expectations about the Story, Timing, Audience adjustments, and Goals.
- Share your self-assessment (strengths and opportunities for improvement) and request feedback on the accuracy of your self-assessment.
- From both junior and senior colleagues, solicit feedback and suggestions about a specific component of the STAGE framework.
- Develop a plan for improvement and specify a time to follow-up with faculty regarding your progress.

Asking for feedback

- Greeting: “Hi, how is the day going for you? Is this a good time for you to give me some feedback on my oral case presentations?”
- Share your self-assessment of your presentation: “I think I have a handle on how to
construct an opening statement and chronologically convey key information in the history of present illness, but I am unclear on whether I am including all the appropriate pertinent positives and negatives."

- Solicit observations and suggestions, in advance: “Would you be able to comment on the appropriateness of my inclusion and exclusion of components of the past medical history, social history, and family history in the present illness?”
- Solicit observations and suggestions, afterwards: “What went well from your perspective? Could you give me some suggestions on how to improve?”
- Make a plan for follow-up: “Would you be able to listen to a presentation in a week to comment on my progress?”
- Express appreciation: “Thanks, that was especially helpful because…..”

Exercise #1: 47 YEAR OLD MAN WITH CHEST PAIN

Part A: The interview

Observe this brief interview (4:41) of a a standardized patient with chest pain by a third year student.

- As you listen, attend to “S”, the “patient’s story”, and focus on the story content and chronology
  - Take notes, if note-taking will help you remember key details
- How well did the student gather information about all 7 elements of the patient’s presenting problems and past history- a more or less complete STORY?
- What is the chief complaint, and what are the key elements of the history of present illness?
- How would you construct a medical version of the patient’s story?
- What do you think is the cause of the patient’s symptoms?
- Construct your own case presentation using the historical data from this interview.

Part B: Student Case Presentation

Watch this Student Case presentation of the patient
with chest pain. Imagine that you are to give the student feedback on the STORY.

- What will you tell the student about the strengths of the presentation style?
- What key content did the student include in the case presentation, and what key content was omitted?
- What will you tell the student about the strengths of the opening statement? What could be improved?
- What will you tell the student about the strengths of the synthesis of the information into the history of present illness? What could be improved?
- Click here to watch a discussion of the presenter’s performance

Part C: Another Student’s Case Presentation

Watch this movie of a different case presentation based on the same patient interview from Part A. Imagine that you are to give this second student feedback on the STORY.

- What will you tell the student about the strengths of the presentation style?
- What key content did the student include in the case presentation, and what key content was omitted?
- What will you tell the student about the strengths of the opening statement? What could be improved?
- What will you tell the student about the strengths of the synthesis of the information into the history of present illness? What could be improved?
- Click here to watch a discussion of the presenter’s performance

Part D: Our Student’s Case Presentations

Check out the video example to see how "our students" present the case. Think again how you would present such a case yourself.
Exercise #2: 40 YEAR OLD WOMAN WITH ABDOMINAL PAIN

Part A: The interview

Observe this brief interview of a standardized patient with abdominal pain. Imagine that you are on rounds observing this student-patient interview. Following the interview, use the STAGE framework to develop a 2-3 minute oral case presentation.

Practice delivering the case presentation in front of the mirror, a video camera or a fellow student. Assess your own presentation, and develop 1-2 questions to request specific behavioral feedback.

Part B: Our Student's Case Presentations

Watch a video where Jimmy present the case. Think again how you would present such a case yourself.

Click [here](#) to see how Dr. Monroe gives feedback on Jimmy's presentation.

---

COMMON MISTAKES IN ORAL PRESENTATION

Improving presentation skill requires a disciplined and systematic approach that includes improving knowledge about what an excellent presentation looks and sounds like, and practicing with peers and faculty to aid you in identifying and trouble shooting problems. Common problems fall into two broad categories: first, information—failing to summarize, organize and transmit coherently huge amounts of information (this requires learning a new jargon); and second, “delivery”—failing to maintain connection and relationship with listeners.

1. **Labored rhythm, with little audience contact** - novice students typically have difficulty tracking all the information and tend to present in a wandering, disorganized and/or desultory fashion. Maintaining eye contact with your listeners means that you should not read your write-up verbatim, and instead use notes. The skill to convert a written history and physical examination into a compressed presentation requires practice, like any other skill. At first, take the time to practice it two or three times in advance. For most learners, it is
helpful to find a classmate or resident who can spend a few minutes listening, give you feedback and watch you try again. Most learners also benefit from audio-taping (or videotaping) in order to gain personal insights. Like any skill, this one is easier for some students than others; so some advanced students may need to continue practicing.

2. **History of present illness too brief** - 90% of correct diagnoses come from the history alone; so do not sabotage your listener’s understanding of the case by omitting important information. The HPI portion of the oral presentation, as a general rule, should take 1/3 to 1/2 of the presentation time. Common pitfalls include incomplete characterization of major symptoms, reporting lists of symptoms instead of a chronological story, omitting pertinent negatives or positive ROS questions, and omitting specific information about past history that relates to the present problem.

3. **Failure to use parallel reference points** - in both write-ups and oral presentations, relate time in “hours/days/weeks prior to admission”. Avoid “at 2:00 in the morning of last Wednesday” or “on May 25th”; instead, say “three hours prior to admission”, or “at 2:00 am, three days prior to admission”.

4. **Editorializing** - avoid comments like “do you even want to hear this?...” or “cardiac examination revealed a systolic murmur….well, I thought heard it, but the resident didn’t…so maybe it isn’t there….I don’t really know....”

5. **Use of negative statements instead of positive statements.** Positive statements add color and accuracy to your presentation. “Chest X-ray shows normal heart size” is better than “chest X-ray shows no cardiomegaly”. “In summary, this patient’s problem is acute dyspnea” is better than “the patient’s problem is rule-out pneumonia”.

6. **Unnecessary and repetitious descriptive sentences.** Overly repetitious sentences become monotonous and lose the listeners. “On pulmonary exam, the lungs were normal...on cardiac exam, the heart sounds were...., on lymph node exam, there were no cervical nodes...” is unnecessary – your listener knows that S1 and S2 are part of the cardiac exam! Use brief descriptive sentences: “an S3 gallop was heard at the left lower sternal border.”

7. **Disorganization** – Every novice learner has this problem. Because students are frequently encountering new illnesses, new twists on extreme human conditions and new situations for presentation, be aware that disorganization can happen even with careful preparation. Rehearsal, feedback, experience with multiple types of problems and situations, and attending to the structure of presentations you hear and admire will each help improve organization. If you sense that you are not on track, pause. Do not make editorial and self-referential comments like “Oh, I can’t believe I forgot to tell you this!” Saying “...in summary, this patient...wait, I forgot to tell you the most important thing...” will kill a presentation. Everyone forgets, and everyone has feelings of embarrassment too, so listeners will help you get all the data on the table, and help you reorganize it, but they will be less charitable if you spend presentation time making a big deal about shortcomings and talking about yourself. Be certain that you have the opportunity to talk with your supervisors about the shortcomings and the associated feelings in feedback sessions.

8. **Lack of proper terminology for physical findings** - for example, “lymph node exam shows some small cervical nodes” is not as descriptive as “...there were three soft tender mobile nodes in the left anterior cervical chain which measure 1 x 1 x 2 cm each...” Commitment to accuracy will improve your physical examination skills.

9. **Naming a diagnosis instead of describing physical findings** - diagnoses belong in the assessment, descriptions in the physical examination. For example, avoid “exam showed the murmur of mitral regurgitation” ...instead say “a 2/6 holosystolic murmur was heard at the apex and radiated to the axilla”. Avoid “skin exam showed psoriatic lesions on the elbows...”.; and instead say “there were several 2 cm. diameter round plaques with silver scale distributed on the extensor surface of the elbows...”

---

**CONCLUSION**

Competent oral presentations help listeners and presenters maintain a high standard of patient care by facilitating coherent information transfer that is essential to high quality clinical
reasoning about diagnosis, treatment, and teamwork.

The STAGE framework can assist learners to organize information and to deliver it clearly in oral presentations, and STAGE provides a structure for practice and feedback.

Acknowledgement: Development of the STAGE framework and the patient vignettes were funded, in part, from The Josiah Macy, Jr. Foundation through the UMASS Macy Mentorship Program in Health Communication Education.

### RELEVANT BEHAVIORS

1. Tell the patient’s **Story** using the organized format.
2. Use an engaging **Style**
3. Confirm your **Timing**
4. Identify your **Audience** and Setting then adjust accordingly.
5. Clarify the **Goals** of your presentation
6. **Elicit** feedback

### LITERATURE REFERENCES

2. Cochran, N. A guide to case presentations. Dartmouth Medical School adapted from McGee, S. University of Washington School of Medicine.
   http://courses.washington.edu/med665/student/presentation.html
Welcome to DocCom Module 38:
"Communication on Healthcare Teams"

by Anthony L. Suchman MD, MA, FAACH; Cathy Risdon, MD; Zeev Neuwirth, MD, MA; Marla Rowe Gorosh, MD; Marla Rowe Gorosh, MD; Julie Crosson MD; Carol Mostow LICSW, MD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Credits:

Authors: Anthony L. Suchman MD, MA, FAACH; Cathy Risdon, MD; Zeev Neuwirth, MD, MA; Marla Rowe Gorosh, MD; Julie Crosson MD; Carol Mostow LICSW, MD

Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.

DocCom implementation: Christof Daetwyler M.D.

Casting of the Standardized Patients: Benita Brown

Standardized Patients as Actors: Liz Fuller, Colleen O’Brien, Kerry Duffy

Clinicians on camera: Anthony L. Suchman, MD, MA, FAACH. Cathy Risdon, MD, Zeev Neuwirth, MD, MA. Marla Rowe Gorosh, MD

Video Director and Producer: Christof Daetwyler M.D.

Video Camera, Light and Sound: George Zeiset B.A.

Video Assoc. Director: Dennis Novack M.D.

Version History:
4.0 - 2/22/2012 Enhanced with HTML5 code and MP4 videos
2.0 - 9/4/2009 Update to DocCom Version 4.0
1.0 - 6/20/2006
Rationale
Anthony L. Suchman MD, MA, FAACH

Questions for Reflection:

1. In your team experience, what are key factors that determine whether a team works together well or poorly?

2. How can the skills you use in the patient-clinician interview be utilized in a meeting with colleagues?

3. What are the consequences for a team when its leader doesn’t know what the next steps are to accomplish its task?

4. What do you do when your team repeatedly circles around the same questions and repeats ineffective patterns of behavior?

5. What’s your reaction when a group appears disengaged, disorganized, or argumentative? What skills might you use to move the group forward?

Key Principles:

1. Be fully and authentically present. Your way of being affects the behavior of others.

2. Diversity and responsiveness are the life-blood of a group and key factors for creativity. Whether you are a team member or team leader, you can use facilitative questions and reflections to enhance dialog and improve teamwork.

3. Group communication processes are similar to clinical ones, and using interaction skills from
other DocCom modules facilitates good team outcome.

4. Learning specific strategies and interventions to begin work, avoiding muddling, and ending well promotes high quality interactions.

5. Helping the quality of interaction to be as good as possible produces the best possible outcomes. Trust the process; let go of preconceived outcomes.

---

**Learning goals:**

**At the conclusion of this module, you will be able to:**

- Describe differences between hierarchical-control and relationship-centered approaches to team function.
- List the attitudes and skills that constitute a relationship-centered approach.
- Describe meeting formats and methods that foster dialog and collaboration.
- Describe parallels between relationship-centered communication processes in clinical and organizational settings.

---

**INTRODUCTION**

In caring for patients, no person works alone. The quality of teamwork and communication has demonstrable impact on patient outcomes, quality and safety, efficiency, patient and staff satisfaction, workforce retention and the capacity to improve work processes. [1]

The stakes could not be higher. In this module, we examine relationships on healthcare teams and describe perspectives, attitudes and skills that any team member or team leader can use to improve both relationships and team performance. Most *DocCom* modules address relationships and effective communication between patients and clinicians, and we stress that application of these principles also enhances relationships between healthcare team members.

---

**HOW WE THINK ABOUT TEAMS**

How we think about teams profoundly effects our expectations and behavior, which in turn influences the behavior of others. In this section, we examine the assumptions and consequences of two common perspectives on teams, one based on hierarchy and control, the other based on relation and emergence.

Beliefs about teams are remarkably self-fulfilling. The way we think about the roles of leaders and team members shapes our perceptions, expectations and behavior, which in turn influences how people behave toward us. Behaviors repeated over time become habits and habits become enshrined as social norms and team culture. We will consider two different team cultures, one based on hierarchy and control and the other based on relation and emergence. [2] Neither perspective is intrinsically right or wrong; rather, each is best suited to particular kinds of teams or situations. In current practice the hierarchy and control approach is used extensively so we highlight the alternative, which we call relationship-centered administration.
Hierarchy and Control

The hierarchy and control approach presumes that leaders know the answers and team members should do what their leaders tell them to do. This approach is detrimental to outstanding teamwork in most situations.

According to the hierarchy and control perspective, the best path to a good outcome is to have a good plan, which the leader is responsible for preparing and executing. As a leader, you have control (exclusive decision-making authority) over a specific “territory” that can be defined geographically (e.g., an inpatient unit or office practice) or by function (e.g., quality improvement or information technology). People work on projects or make use of resources within that territory only with your approval. You control the activities of the team members, specifying what work they do and how they do it, and holding them accountable. Leadership is equated with expertise: you are assumed to have the greatest knowledge and skill in your domain. The role of team members is to carry out your directions, respecting your judgment and not getting involved in the work of other territories and teams without permission.

The hierarchy and control perspective has the advantage of quick and orderly decision-making, is appropriate when a standardized process needs to be carried out with precision and dispatch, and without variability (e.g., the acute response to a patient in full cardiac arrest). Only one person leads, and conflicts over decision rights and jurisdiction are minimal. And with accountability resting with you, the leader, team members are spared the anxiety of taking personal responsibility for any of the group’s failures. Nonetheless, we recognize limitations of this approach for the functioning of most teams. Concentrating authority and responsibility with you reduces the initiative and motivation of other group members. Communication and collaboration between teams is encumbered by the need to go through team leaders rather than directly between members of your respective teams. Unrealistic expectations of control create anxiety: when things don’t go as planned, the ensuing struggle between you and your team members over who is responsible diverts attention and effort from the work at hand. The apparent simplicity and efficiency of hierarchical decision-making is often illusory.

Relationship-centered Administration

The relationship-centered approach involves paying careful attention to communication and relationship processes. The leader’s role is to engage each team member’s participation and creativity and to foster good dialog while also maintaining accountability.

An alternative way of thinking about teams is the relationship-centered approach. This perspective assumes that best team performance emerges from good interpersonal process. As team leader, you attend closely to the quality of communication and relationships (a responsibility that the team members also share). You recognize that differences and unique perspectives are the source of creativity and adaptability, so you foster an environment in which individuals are comfortable bringing forth differing perspectives, explore each other’s opinions and are open to being changed. Plans emerge in the course of the team’s conversation and benefit from everyone’s thinking.

Using a relationship-centered approach, you strengthen commitment and motivation by engaging team members as partners, trusting and developing their capacity. You give team members wider latitude in determining how to do their work and in collaborating directly with members of other teams. You still hold authority and are responsible for maintaining accountability, but you do so in a relational fashion, for example, by negotiating individual goals and performance criteria. You view accountability as a form of service, an opportunity to help your team and its individual members realize their best potential. Occasionally you remove someone from the team, when you
recognize and correct a mismatch of person and role that serves neither that individual nor the team well. Team members are responsible for participating in partnership, volunteering their observations and ideas honestly and respectfully. Leadership flows throughout the group. Anyone can suggest a new idea; anyone can make a reflection or suggestion to help facilitate the team’s interactions.

**ATTITUDE**

Before we turn to methods that foster teamwork, we must first consider attitude, for the result of any strategy or skill that you use depends heavily upon the spirit in which you use it.

Thomas Watson Jr, who built IBM, said, “The basic philosophy of an organization has far more to do with its achievements than do technological or economic resources, organizational structure, innovation and timing.”[3] We describe below some attitudes and basic philosophy that support outstanding teamwork.

### Improvisational team consciousness

Thinking about meetings as an improvisational performance rather than a predetermined script facilitates collaborative group participation and the emergence of unpredictable and creative possibilities.

We often come to meetings with our own personal outcomes in mind – our plans, wants, grievances, opinions, data, spreadsheets, slides, and so forth. It’s as if we’re musicians who arrive to orchestra practice ready to perform our individual solos but not particularly interested in hearing what others play; or worse, only interested in listening to others for the purpose of critique and criticism.

For a relational meeting you arrive practiced and prepared, ready to listen responsively to others and to support their performances – like a jazz ensemble in which your own riff is highly influenced in the moment by what and how the other musicians are playing. The resulting improvisational performance is an emerging, synergistic creation that is greater than the sum of its parts – an outcome whose specifics could not have been designed or predicted ahead of time. [4]

### Learner's mindset

The willingness to adopt a non-expert stance and to continue to learn from others creates a respectful team environment, one that is unshackled from the mindset of “knowing”.

In our healthcare culture, the expert or ‘knowing’ mindset is an attitude that severely inhibits team function. We are all trained to be knowers, and clearly knowledge and knowing are important-- as responsible professionals, we must have a certain level of knowledge and skill. In team situations, however, the ‘knowing’ mindset can prevent us from listening and learning. Presuming that we 'know' the problems and solutions leaves little room for hearing other's thoughts or opinions, and even less room for combining our individual knowledge in creative ways.

An alternative approach would be to hold your perspectives more lightly and to be willing to explore someone else’s perspective even as you continue to hold your own. This mindset is often
referred to as the humble learner’s or ‘beginner’s mind’ [5] It’s an approach of curiosity and open-mindedness rather than dogmatic close-mindedness. It’s the type of mindset you have when you come to a new situation, or that a social scientist brings to the exploration of a new culture or setting. It frees you from the shackles and burden of your own knowing and allows you to listen, learn, wonder, and grow.

Value difference

Members on high performing teams value their differences and respectfully challenge and disagree with each other, stimulating dialog and creativity.

The voicing of differences is critical to creating value in an organization; for only through exploring our disagreements can we learn from one another. People too often sit in meetings in silent disagreement. Perhaps they do not care enough to speak up, or do not wish to challenge someone for fear of hurting their feelings, or perhaps they fear rejection, exclusion or humiliation. Indeed, it takes courage and skill to speak up honestly and respectfully – to be truthful and also acknowledge other peoples’ truths. This courage and skill are critical ingredients of meaningful conversations and productive meetings. In one very successful organization that we’ve studied, there’s a saying – ‘if two people agree with each other then one of them is superfluous’. Difference stimulates new ideas and possibilities. Silent disagreement deprives others of the opportunity to receive important feedback, and foments anger, resentment and passivity. Silence also robs us of the opportunity to learn and grow through having our own ideas challenged.

Check out the video example about "value difference" on the left.

An alternative approach is to locate the courage to acknowledge how much you care, to offer your honest, genuine perspective in a respectful way that skillfully invites others to voice their disagreement in turn. Expressing yourself genuinely at meetings and encouraging others to do so enhances the possibilities for understanding and creativity. This approach values difference and diversity and creates an open and participatory environment. Passive resistance, the silent killer, evaporates.

Appreciate capabilities of others

An approach that appreciates capacities and successes, rather than one that focuses on flaws and problems, allows teams to create a better future by bringing along the best of their past.

The word ‘appreciate’ has a number of meanings, including both to recognize the value in someone or something, and to increase the value of someone or something. Our experience is that individuals in organizations seldom do this – we often underestimate the value of our colleagues and co-workers, much less elevate or increase their value. We look for flaws or problems without recognizing the good things, and we may also apply that same “pathologizing gaze” to ourselves.
We rarely make the effort to assist one another in appreciating that value.

**Check out the video example** about "appreciate capabilities of others" on the left.

An alternative approach is one of appreciation. Experience and experiment have shown that the more capacity you perceive the more likely it is that people will rise to meet those expectations (a self-fulfilling prophecy). So in reflecting on your daily work and especially in promoting change, you can cast your attention out toward the positive – what’s working, what we want more of – rather than towards what’s not working.[6] During meetings you can value team members through recognizing each other’s capacities and increase your value through acknowledging the team’s successes.

**Become comfortable with uncertainty**

The ability to tolerate uncertainty and hold back the rush to resolution creates space for team members to brainstorm, present and tweak new ideas and implement creative solutions.

One of the pitfalls of many meetings is the overwhelming desire to describe and quickly fix problems, to find solutions, to make decisions and check those items off the list. Our quest for control makes us anxious with uncertainty, because we equate uncertainty with incompetence, failure or difficult conversations and interactions. Too often in our rush to resolution, we focus prematurely and narrow our vision of the range of possibilities. In doing so, we miss the voices and ideas at the periphery – innovations that are just the germ of an idea, or that might make little sense at first blush but which eventually could offer new solutions. We fail to allow space with uncertainty in order to see what new patterns might emerge.

An alternative approach is to embrace “not knowing” – to recognize that it can be a virtue rather than a fault. Removing the fears associated with uncertainty makes room for free-flowing brainstorming and open dialog, and allows a group to go beyond formulaic tools or approaches. It also lets a group recognize when it needs more time to simply sit with the question.

**Reflect on process**

Spending time on ‘how we are working together’ boosts efficiency by resolving inevitable frictions and misunderstandings before they become serious impediments to productivity.

In our desire to be productive, our meetings often concentrate attention on the content of the work at hand. We’re all about the ‘what’. Rarely do we focus on the patterns of power and relating and the values we enact as we work—the ‘how’ of working together. Many dismiss such reflection as ‘touchy-feely’, ‘navel-gazing’ and a fruitless a waste of time. But what really wastes time and impairs team performance are conflict, misunderstanding and mistrust, nearly all of which is preventable and solvable if we take the time to reflect on how we are working together.
An alternative approach is to recognize the importance of paying attention to relationships and communication processes. Exploring each other’s perceptions and addressing the inevitable frictions and misunderstandings of daily work while they are still minor prevents enormous amounts of extra work. A regular discipline of reflecting on “how we are working together” can improve efficiency and save time. Peter Drucker, one of the greatest management scholars, described this type of activity as the most critical and primary responsibility of each and every individual in an organization. [7]

**COMMUNICATION SKILLS**

Our daily lives are packed with interactions as we work on teams, meet in hallways, and congregate at meetings. Each interaction is an opportunity to strengthen relationships, exchange information and generate ideas.

This section describes skills that enhance your awareness, responsiveness and effectiveness as a supportive co-worker, meeting participant or team leader. The skills for effective clinical communication described in other modules of DocCom are valuable in fostering teamwork and relationship-centered administration. When we use these interactional skills in meetings and other conversations, we create patterns of relating that fashion and shape a relationship-centered culture within our teams and for the organization as a whole.

**Self-awareness**

You can learn to notice where you are focusing your attention and what assumptions and judgments you are making. You can be aware that an inner voice is distracting you and return your attention to what you are experiencing right here, right now.

Have you ever noticed your mind during a meeting? So often an inner voice judges what is happening or rehearses what you intend to say next, or perhaps occupies your mind with ideas not related to the present interaction. These ever-present messages can be distracting and keep you from being fully present; or they can focus you on the present and your current experience. Whether they are distractions or insights depends upon your capacity to observe yourself – your self-awareness.

Self-awareness encompasses mindfulness of body, feelings and mind itself, as noted in Table 1

<table>
<thead>
<tr>
<th>Types of Mindfulness</th>
<th>Examples of self-observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mindfulness of the body</td>
<td>breath, contact, movements, communication via body posture, proximity to others; unpleasant and pleasant bodily states: arousal, “sinking feeling”, churning gut, restlessness, “goose bumps”</td>
</tr>
<tr>
<td>Mindfulness of emotions</td>
<td>excitement, fear of embarrassment, anger, anxiety, heaviness, acceptance, (identification of your emotions may heighten sensitivity to others’ emotions – similar to counter-transference with patients)</td>
</tr>
<tr>
<td>Mindfulness of mind</td>
<td>alertness/attentiveness, distraction, associations, assumptions, fears, desires</td>
</tr>
</tbody>
</table>

(for a further discussion of mindfulness and self-awareness, please see module 2)
Active listening

Active listening is more than passively receiving information. Reflect back what you’ve heard to show speakers that you understand what they are communicating. An inaccurate reflection will show them both that you are interested and that you’ve not yet understood.

As a skilled listener you convey genuine interest through nonverbal behaviors such as posture, eye contact, head and body movements and facial expressions, and also through an open and curious line of inquiry. Expressing your curiosity by not steering conversation towards a premeditated goal allows speakers to lead you through their ideas and experience. Skillfully echoing speakers’ phrases or paraphrasing what you’ve heard not only demonstrates your interest in accurately tracking their thoughts, but also creates an opportunity to discover what you do not understand to help you get back on track.

Present your thinking

Presenting your perspectives enhances both the diversity available to the group and the willingness of members to contribute to the dialog.

Speaking your truth contributes to a culture of frank open discussion and serves to enhances that culture when your perspective differs from others’. Explain how you formed your opinion and give the data on which it’s based. Take a moment to describe what meaning it has for you or what you have at stake. Your frankness can make it easier for others to speak up. Your transparency enhances openness, and encourages others to make their assumptions and reasoning available to all.

Harness difference and diversity

Diversity is valuable because it opens new and broader possibilities. Team members who manage to “look out” through each other’s eyes understand situations more comprehensively and wisely than they could with a narrower, individual perspective.

Underlying all our positions are assumptions, beliefs, rationales and logic. Striving for self-awareness of these underpinnings enables us to hold them up for examination. Making them available to inquiry by others and exploring the way others think can open us to new ways of understanding, which cannot be done if we “dig in our heels” and cling to “the way it is.” Maintaining a beginner’s mind – being willing to “not know”– allows the differences to become the spark of a transforming new idea. Resist the common temptation to mistake difference for rejection or to make immediate judgments about what is right or wrong. Hold multiple perspectives simultaneously and stay engaged with exploration of differences so as to move beyond “either-or” and recognize more complex realities.
Stay engaged despite conflict

Displays of strong emotions can evoke reactions that destabilize the group’s focus. If we get defensive, lash back, give in to the temptation to withdraw or smooth over differences instead of responding compassionately, we miss creative or transforming insights.

Seeking creative and transforming results inevitably surfaces conflicts between team members. Awareness of your own emotions, the ability to name them and a willingness to notice and name others’ feelings is a crucial factor in group success. Acknowledging and naming your own or others’ emotions helps groups creatively hold the tension of the conflict and re-open us to dialog. The willingness to hear each voice even when passionately expressed builds trust and gives the group the benefit of each member’s truth. Both demonstrating respect and partnership using relationship-building statements (PEARLS – see Table 2 below) and restating and checking common goals keep the team vital and restores its focus. Subjects that would otherwise become sources of discord and fractiousness become discussable. Even more, they become windows to deeper insights.

Table 2: PEARLS build team relationships.

Relationship statements, summarized by the mnemonic PEARLS, were presented in the context of the patient-clinician relationship (see modules 6, 13). These communication skills are equally useful for building relationships in teams. The chart below offers examples. (adapted from [9])

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Collaboration and teamwork, common goals and vision, joint problem solving.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>Recognize and address emotion. Put feelings into words. Point out low/high energy levels.</td>
</tr>
<tr>
<td>Apology, Acknowledgement</td>
<td>Admit errors, show concern for mistakes and take responsibility.</td>
</tr>
<tr>
<td>Respect</td>
<td>Give credits, appreciative comments and positive feedback. Value group members' behaviors.</td>
</tr>
<tr>
<td>Legitimization</td>
<td>Normalize and validate feelings, choices and responses.</td>
</tr>
</tbody>
</table>

"We all want what’s best for the patient. I know that we will figure this out together."

"You look frustrated about this." Or, "I'm feeling low energy right now, can we take a quick check on how others are feeling?"

"I acknowledge that I should have contacted each of you sooner about this."

"I appreciate that you’ve brought that point up. "I’m impressed with the strength of your convictions."

"I don't blame you for feeling that way. Anyone in your shoes would feel the same."
Support

Maintain an optimistic, open attitude.

"I know we're going to figure this out. "I'm willing to stay in conversation about this."

Make process reflections

Members who comment on group interactions can stimulate a team to adopt more congruent and transparent dialog patterns that contribute to both the team’s cohesiveness and its effectiveness.

Awareness of your own emotions or degree of engagement in the dialog can help you monitor other members’ engagement. This tracking is the organizational equivalent of using your own feelings (counter-transference) to understand those of a patient. Take a moment to observe your feelings during a difficult or confusing spot, and then observe the other team members. Their posture, expressions and other nonverbal signs may help you discern their feelings and engagement. At such moments, you might notice incongruence between what you discern and what is being said; for example, expressing verbal agreement while showing disengagement through flattened voice tones or slouched posture. Disengagement sometimes indicates the presence of important issues that no one is bringing forth for discussion.

Speak your observations as a method of calling attention to the team’s current behavior and situation. This provides the group an opportunity to be more mindful of its own process, to consider new and more forthright interactive patterns and to regulate itself more effectively. Your transparency may stimulate members to develop their own self-awareness and communication skills. (See module 14 about "nonverbal communication")

MEETING PROCESSES

“Microskills” of relationship centered practices are intended to introduce and reinforce patterns of partnership and collaboration. They can help your team break out of frustrating patterns of relating so that meetings become more effective and engaging.

In this section we hope to give you tips on improving your meeting performance – whether as a participant or the chair. Executive skills such as time-keeping, rules of order or decision-making processes are important, but not our focus. [10] Instead, we describe meeting strategies that build on the attitudes and skills considered above.

In meetings, how we interact and respond to one another can have more long lasting impact on outcomes and results than what we actually talk about. So it’s worth learning interactive skills that respond to typical meeting dynamics– and knowing that any new ways of participating that you employ may eventually diffuse and spread in ways that impact work in other areas of your organization.

Meetings have a beginning, middle and end – each with a specific purpose. We will consider each of these in turn.

Beginning a meeting

The first 10 minutes of the meeting, devoted to greeting, checking in and establishing agenda, set the stage for the tone and effectiveness of the entire meeting.
Table 3 lists the opening tasks of a meeting and itemizes specific contributions for which the Chair and Participants should take responsibility. Chairs and participants who attend to these tasks bring team members together and address problems and concerns that can delay or derail the work if not managed early. We give more specific and detailed consideration to check-in and agenda negotiation in subsequent paragraphs.

**Table 3 – Beginning a meeting**

<table>
<thead>
<tr>
<th>Task</th>
<th>Chair’s Contribution</th>
<th>Participant’s Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gathering</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start/Stop on Time</td>
<td></td>
<td>Arrive on time or send advance notice if late</td>
</tr>
<tr>
<td>Greet participants as they arrive</td>
<td>Ensure participants are comfortable</td>
<td>Acknowledge and greet the chair and others in the room</td>
</tr>
<tr>
<td>Ensure participants are comfortable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make eye contact with all participants; thank them for coming</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Welcoming, Introduction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide introductions for those who don’t know one another</td>
<td></td>
<td>Introduce yourself to participants you don’t know</td>
</tr>
<tr>
<td><strong>Check-in (see text below)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clarifying, Negotiating the Agenda</strong></td>
<td><strong>Agenda setting (see text below); ensure that purpose of meeting and agenda are clear to all participants; for additions/clarifications as needed</strong></td>
<td>Be prepared to speak to the issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggest additional agenda items relevant to the group</td>
</tr>
</tbody>
</table>

**Check in**

An intentional check-in supports a team’s effectiveness by building trust, clarifying individual situations, removing distractions and attending to inclusiveness.

*Check out the video example* about "checking in" on a team that meets on a regular base.

Check-in is a simple technique which can achieve many things:
• assist participants in transitioning from a previous activity and setting aside extraneous concerns and distractions; reorient and focus participants on this team’s task.

• improve trust and build relationships by helping participants know each other better.

• invite every participants’ voice into the room at the very outset; bring everyone together

• enhance interational skills that can improve team function

Check out the video example about "checking in" on a team that meets for the first time.

Table 4 outlines check-in formats, and includes sample questions. In each format, the chair and other participants should give each other the opportunity to “pass”. Forcing people to self-disclose can diminish the sense of trust and safety in the group.

"Whoever would like to start, please do and others please join in as you are ready...And as always, please feel free to pass."

In the press of urgent business, it’s often tempting to skip check-in to “get on with the work.” This is usually a false economy. Helping people get connected and calibrated makes the conversation more efficient and less prone to time-wasting distractions, misunderstandings and conflicts. Check in may occur before or after you negotiate the agenda. Experiment with this! Find out what your group prefers.

Table 4: Several formats for check-in

<table>
<thead>
<tr>
<th>Name of Format</th>
<th>When to Use</th>
<th>Advantages</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused Personal Check-in</td>
<td>Groups that are new to one another</td>
<td>May help increase trust, improve quality of participation</td>
<td>I am aware this group hasn’t worked together before...</td>
</tr>
<tr>
<td></td>
<td>Trying to re-establish groups that have not been together for a while</td>
<td>Can start the meeting in a way that includes everyone – Questions can be chosen to increase sense of warmth, fun, competence of group members</td>
<td>Can I suggest we do a brief check-in to help us get to know one another a bit better? Whoever would like to start, perhaps you could tell us briefly what....</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>...was the highlight of your last vacation?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>...was the most interesting thing you learned at the last course?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>...is the best book you’ve read recently?</td>
</tr>
<tr>
<td>Open</td>
<td>Teams that</td>
<td>Allows for ongoing team calibration</td>
<td>Let’s start with check-in – whoever would like to start – what would you</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Check-in meet regularly “Who are we in this moment?” as we begin our meeting like the group to know about where you’re at today?

Review agenda in advance

Appreciative Check-in Teams that work together regularly Be prepared to speak to the issues I’d invite each of you to describe a moment of success – something that’s gone particularly well – since we last met.

Suggest additional agenda items relevant to the group

---

**Negotiate the Agenda**

Negotiating an agenda as a group ensures that everyone has the chance to clarify the “shared purpose” and content of the work. At the process level, this activity underscores the collaborative intentions of the chair.

Negotiating an agenda facilitates sharing responsibility for managing the group’s time and planning its work. Agenda setting is similar to the beginning of a clinical interview when you discuss the shared goals for the appointment, establishing the values of shared responsibility and collaboration. To negotiate an agenda, you can either ask for last minute changes to an agenda that has been sent out ahead of time, or you can receive suggestions to construct an agenda on the spot. Once all topics are listed, you can decide upon sequence and priority. If there are too many items for one meeting, you can decide together how and when to address the other items.

---

Avoid Muddled Middles

Meetings commonly derail or lose focus. The leader and all participants share responsibility for attempting to change an ineffective pattern by suggesting that participants try a new strategy.

You’re all checked-in; the agenda is approved. People are engaged, energy is high; you’re moving through the agenda, making decisions and creatively exploring important issues. Meetings can proceed that smoothly, but sometimes they don’t. We might find ourselves rehashing old issues or
re-enacting ineffective communication patterns. Perhaps participation is low, or the same one or two people monopolize the conversation. The meeting gets sidetracked, energy drops. Table 5 presents some common stuck situations and suggests interventions for managing them. None is guaranteed to work – but trying new interventions is essential when your current practices aren’t working. *Any participant* (not just the chair) can suggest or utilize these techniques.

Check out the video example of ineffective communication patterns. What patterns can you identify, and how would you remedy them within a meeting?

Table 5: Methods for moving a team away from ineffective patterns

<table>
<thead>
<tr>
<th>Description of Ineffective Pattern</th>
<th>Possible Interventionss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough time to explore issues properly; not everyone can contribute</td>
<td><strong>Parallel Conversations:</strong> invite pairs or other small group to discuss an issue for 5 minutes with or without “reporting back” (the additional discussion often helps move everyone along). Stories are effective experiences to share in dyads. [Click here for an example movie showing &quot;pairing up&quot;]</td>
</tr>
<tr>
<td>Same people talk all the time; never hear from “quiet” ones</td>
<td><strong>Go Around:</strong> Each person is invited to take a turn to speak without interruption and always with the opportunity to pass or, if they are not yet ready to speak, to come back to them later.</td>
</tr>
<tr>
<td>Disorderly conversation; many people trying to speak at once</td>
<td><strong>Talking stick:</strong> One can only speak while holding a symbolic “talisman” – a ceremonial stick or bean bag or any other object. Sometimes a little structure helps to ensure hearing the full diversity of opinions and to slow down conversation enough to listen to one another. [Click here for an example movie showing the &quot;talking stick&quot;]</td>
</tr>
<tr>
<td>People continue asserting opposing views without listening to each other</td>
<td><strong>Nominal group process:</strong> This variation on the Go Around is a rapid brainstorming technique. Proceeding around the room in order, participants make one brief suggestion at a time which is recorded on a blackboard or flip chart without discussion. The brainstorming continues for as many rounds as necessary until there are no further new ideas. Only then are the ideas discussed and evaluated.</td>
</tr>
</tbody>
</table>

**Balancing inquiry and advocacy:** Effective group participation means inquiring in to the point of view and needs of others as ardently as you advocate for your own. It also implies a willingness to be changed by what someone else says. Peter Drucker, in his last published article, admonished executives to “listen first, speak last”. [4]
Participants are not saying what they are really thinking.

**Naming the elephant:** Giving voice to what is not being talked about. Describe the issue or the relational pattern in a descriptive and non-judgmental way, e.g.: “I notice that we’re not talking about whose staff is going to be cut” or “We haven’t yet addressed the conflict that’s in the room.” You can also use a Go Around to ask “what important things are we not talking about?”

**Wicked questions:** Sometimes there’s a way of tilting an issue 180 degrees or coming at it from a paradoxical direction. For instance, instead of the question – “how do we find more time for our quality meetings” you might ask “how does paying so much attention to meeting about quality interfere with our ability to provide quality service?” Or “what would a system that was perfectly designed to fail look like?” A wicked question usually starts with “how” – often there is no clear answer. A good wicked question will help surface a paradox or tension which can be fruitful to explore more deeply. [11]

**Actively seek disagreement:** “I’ll bet there are some other perspectives on this, and it would be valuable for us to hear and understand them.”

**Reflective silence:** give people 1-2 minutes of silence in which to gather their thoughts before returning to issue at hand. This can also be useful after a very intense and successful piece of dialog. Click here for an example movie showing "reflective silence"

**Meta-reflection:** take a time out from the conversation for a Go Around inviting people to reflect on how the conversation is going.

**Reflective self-disclosure:** As an alternative to observing what is happening with the group, it can be facilitative to observe what is happening for you. For example, “I’m having this gnawing feeling in my stomach at this moment. Something is making me uncomfortable and I’m not quite sure what it is.” Or, “I notice that I’m feeling really antsy. I guess I’m hoping we can get into a deeper conversation.”

---

**End Elegantly**

The end of a meeting is also the beginning of your subsequent work – and of your next meeting. It’s an opportunity to clarify commitments (a brief summary of actions and decisions) and to improve the team’s capacity for feedback and working together. A brief debriefing or checkout is an effective technique for building relationships and helping the team “calibrate” how it’s working together.

As a meeting moves toward closure, summarize any agreements, decisions and action commitments that members made. Take this opportunity to ensure that everyone has a common understanding and remind people of their specific tasks.

Rather than ending with that summary, however, a useful and stimulating practice is to conduct a quick debriefing or check out. The structure is similar to check in, and extends an invitation to participants to reflect on the meeting through a “Go-round” (with the invitation to pass) or “popcorn style” (in no order, each person speaks when ready).
Participants have an opportunity to recognize one another’s contributions and to give positive reinforcement to behaviors that contributed to the meeting’s success. This consolidates learning and increases the likelihood that those behaviors will occur in subsequent meetings. Also, like check-in, it helps people get to know each other better and builds relationships.

Table 6 presents several possibilities for the specific focus of a “check out.”

Table 6: Suggestions for “Check-out”

<table>
<thead>
<tr>
<th>Type of Debrief</th>
<th>Description</th>
<th>Potential Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appreciative Debriefing</td>
<td>“I’d like to invite each of us to check out by telling another person of a moment when that person said or did something that was helpful to you.”</td>
<td>Reinforces desired behaviors. Builds positive regard among team members. Builds team capacity by noticing and sharing what works.</td>
</tr>
<tr>
<td>Action Steps</td>
<td>“I’d like to go around with a check out and have everyone claim an action step they are committed to trying in the next week.”</td>
<td>Clarifies and consolidates commitment. Ends meeting on positive note – helps in transition from “decision” to “action.”</td>
</tr>
<tr>
<td>Personal reflection</td>
<td>“I’d like to invite each of us to check out with a brief word about how we were impacted by the meeting today – perhaps something you will think about and carry with you until our next meeting.”</td>
<td>Helps team deepen understanding of one another. Shows how shared events impact each one of us. Provides opportunity for personal consolidation of meaningful experience.</td>
</tr>
<tr>
<td>Open invitation</td>
<td>“Let’s have a brief checkout – where are you at now that our meeting is drawing to a close?”</td>
<td>Invites personal reflection and calibration between team members. Builds group “history.”</td>
</tr>
</tbody>
</table>
A team is at its best when all its members can be fully present, holding the richness of their diversity as their most valuable resource, and when they can simultaneously influence and be influenced by each other.

These are the conditions under which new ideas are most likely to emerge; this is the path to innovation and resourcefulness. And most important, participants’ presence and openness to influencing each other makes the team’s work effective, enjoyable, creative and meaningful.

In this module, we’ve examined a comprehensive and practical framework for improving communication and partnership on teams, including attitudes, skills and strategies. Perhaps an effective way to summarize this material is to return to comparison of the hierarchy-control perspective and relationship-centered administration, and to fill in more detail (Table 7).

### Table 7

<table>
<thead>
<tr>
<th>Leader's role</th>
<th>Hierarchy and control perspective</th>
<th>Relationship-centered administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>The leader</td>
<td>Director, expert</td>
<td>Facilitator, coordinator</td>
</tr>
<tr>
<td>Leadership's focus</td>
<td>The leader</td>
<td>Shifts through the group</td>
</tr>
<tr>
<td><strong>Attitudes</strong></td>
<td>Soloist</td>
<td>Ensemblist</td>
</tr>
<tr>
<td></td>
<td>Knowing</td>
<td>Beginner's mind</td>
</tr>
<tr>
<td></td>
<td>Disagreement as problem</td>
<td>Disagreement as resource</td>
</tr>
<tr>
<td></td>
<td>Correcting flaws</td>
<td>Enlarging capacities</td>
</tr>
<tr>
<td></td>
<td>Valuing answers, certainty</td>
<td>Valuing questions, not-knowing</td>
</tr>
<tr>
<td></td>
<td>Advocacy (or telling)</td>
<td>Inquiry and advocacy (or listening</td>
</tr>
<tr>
<td></td>
<td>Influencing others</td>
<td>and telling)</td>
</tr>
<tr>
<td></td>
<td>Eliminating difference</td>
<td>Being influenced and influencing</td>
</tr>
<tr>
<td></td>
<td>Focusing attention on goals</td>
<td>others</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td>Agenda set by leader</td>
<td>Valuing and exploring difference</td>
</tr>
<tr>
<td></td>
<td>Task-oriented</td>
<td>Focusing attention on the group's</td>
</tr>
<tr>
<td></td>
<td>Impersonal</td>
<td>process and goals</td>
</tr>
<tr>
<td></td>
<td>Focuses attention on problems to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>be solved (evaluative)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strong people dominate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conflict avoidance</td>
<td></td>
</tr>
<tr>
<td><strong>Meeting processes</strong></td>
<td>Agenda set by group</td>
<td>Relationship-building and task-</td>
</tr>
<tr>
<td></td>
<td>To be solved (evaluative)</td>
<td>oriented</td>
</tr>
<tr>
<td></td>
<td>Everyone participates</td>
<td>Personal</td>
</tr>
<tr>
<td></td>
<td>Honesty; naming the &quot;elephant&quot;</td>
<td></td>
</tr>
</tbody>
</table>

AnnotatedVideo (not shown in print-out text)

**RELEVANT BEHAVIORS**
Being present and making facilitative use of self

- Make facilitative use of self disclosures about your own thoughts, feelings and responses during the meeting.
- Disclose how others have affected you.
- Bring your own differences forward.
- Disclose personal uncertainty.

Using core communication and collaboration skills

- Reflect back your understanding of participants’ words and non-verbal behaviors.
- State appreciation for views, capacities, capabilities and contributions of others
- Explain your views and the reasoning behind them.
- State appreciation of difference and diversity as resources
- During conflict; state shared goals and values and appreciate the capacities of those you disagree with.
- State your willingness to be influenced by others
- State your tolerance for uncertainty and your willingness to allow time for answers to emerge.
- State your belief in the constructive potential of collaborative conversation.
- Use relationship building statements.

Chairing or participating in a meeting:

- Facilitate check-in at the beginning of the meeting
- Negotiate an agenda and state your interest in adjusting when group departs from it.
- Demonstrate willingness to use conversational formats and facilitation methods that evoke diversity and facilitate dialog; such as:
  - Reflective silence
  - Parallel conversations
  - Brainstorming/Nominal group process
  - Go Around/Talking stick
  - Wicked questions
  - Appreciative inquiry
  - Reflective narratives
  - Balancing inquiry and advocacy
  - Meta-reflection/Naming the elephant
- Demonstrate willingness to help the group track and adjust its process using methods such as:
  - Disclosing your experience of the group
  - Inviting group members to reflect on what they are experiencing
  - State your awareness and understanding of interaction patterns
  - Name unspoken themes or unaddressed issues
  - Clarifying your understanding of group’s purpose, mission, goals
- Facilitate closing a meeting, using methods such as: action steps; appreciative debriefing; personal reflection; open reflection

Literature References:


loading..

Welcome to DocCom Module 39:
"Communicating with Impaired Clinicians"

by Peter Barnett, MD, MPH

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details
Credits:

Authors: Peter Barnett M.D.
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Standardized Patients: Alison Ferris MD, Radha Menon MD, France Doyle MD
Clinicians on camera: Peter Barnett M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.

Version History:
5.1 - 2/28/2014 revision by Peter Barnett, M.D.
4.0 - 2/22/2012 Enhanced with HTML5 code and MP4 videos
2.1 - 11/30/2010 revision by Peter Barnett, M.D.
2.0 - 9/5/2009 Update to doc.com Version 4.0
1.0 - 6/29/2006

Rationale

Peter Barnett, MD, MPH

The Intern's View

Video is loading...

The Doctor's View

Video is loading...

Questions for Reflection:

1. How do you define a fully functioning clinician?
2. What does it take to function fully, and continue through an entire career?
3. Think of a time when your efforts to work at a high level were challenged. What was it like? How did you deal with it? With whom did you speak about it, and how did they respond? What would have helped you deal with it even more effectively?

4. What do you think of when you think of an impaired or distressed clinician?

5. Recall a situation in which a peer appeared impaired in some way – or imagine such a situation. What would you say, and to whom? Where could you get help about this? What are consequences if you do nothing?

---

**Key Principles:**

1. Every clinician experiences times when their capacity to perform well professionally is subject to stress of some kind.

2. Ethical and legal mandates charge us to intervene with any colleague who might be impaired.

3. Many impairments can be prevented, and others effectively treated.

4. Initiation of conversation with a possibly impaired colleague requires courage to overcome personal and societal obstacles, particularly when the colleague is of “equal or higher” status.

5. Effective intervention calls for respectful attitudes and empathic communication skills.

6. Some situations require immediate and definitive intervention by the person witnessing the unacceptable behavior.

---

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe diverse ways in which a high level of professional performance can be impaired.

- Remember a time when you had difficulty performing well as a clinician or student, and describe the contributing factors, how your work was affected, and how colleagues communicated with you.

- List reasons for taking action about impaired colleagues, rather than remaining silent.

- Describe and demonstrate skills for effective communication with colleagues who are distressed or impaired in some way.

**Note:** *This Module is not intended to prepare participants for the professional assessment, treatment, or monitoring of impaired clinicians, but for the recognition of possible impairment and initial intervention by/as a colleague.*
INTRODUCTION

Clinician rates of impairment from substance abuse and from psychiatric and physical disability are at least as high as the general population.

Successful conduct of work as a healthcare provider requires high levels of cognitive ability, emotional balance, unimpaired consciousness, flexibility and competence with communication and teamwork skills, as well as a physiological state that is stable and suited to the individual’s practice. Every clinician experiences times when their capacity in one or more of these domains may be diminished by stressors such as physical or emotional illness, family or social problems or dysfunctional work environments.

As a clinician, you owe allegiance to both your colleagues and to a professional standard of ethics and behavior, and above all you owe a commitment to patients’ safety.

The World Health Organization (1948) defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity”.

POOR STRESS ADAPTATION PRODUCES IMPAIRMENT

Clinician training may promote maladaptive responses to stress.

The strengths that assure success in medicine, such as diligence and high degrees of responsibility and compulsivity, may also predispose clinicians to considerable internal stress, particularly as control over the workplace is relinquished to group practices and corporate management. We often fail to identify our distress and ask for help. Additionally, we seldom intervene with distressed colleagues. In a 2010 study only 64% of surveyed clinicians agreed with the commitment to report possibly impaired colleagues.

In medical school and residency, the “hidden curriculum” reinforces coping silently with sleep deprivation, a demanding specialty rotation or the inappropriate senior attending. In response to such stresses, you may have learned maladaptive or even unprofessional strategies. Consider the distancing tactic of calling undesirable or demanding patients by sarcastic or demeaning names.

Clinicians must adapt to the many stresses intrinsic to the practice of medicine, and life itself. On many occasions our professional functioning is impacted by stress. Stressors include periodic sleep deprivation, mistakes (whether hidden or known only to the clinician), deaths of beloved patients, legal, economic or practice difficulties, and “ordinary” life stressors such as the arrival of a new child, death of a parent or emergence or complications of a personal health problem. Continual effective functioning in medical practice requires personal resilience and effective coping skills.

Among clinicians, there is at least a 16% lifetime incidence of major depressive disorders. Estimates of clinician alcohol dependence range between 8% and 15%, compared with 13.5% in the US adult population. Data on physical illness among clinicians are scant but an estimated 10% of clinicians will experience disabling physical illness at some time in their careers.

Many clinicians successfully adapt. Further, diligent and careful clinicians often compensate for such difficulties as sensory disturbances (deafness etc), diabetes, well-controlled bipolar disorder, cancer and orthopedic impairments.

IMPAIRMENTS AND DISRUPTIVE BEHAVIORS
The list of situations that impair high level professional functioning is diverse and manifold, limited only by our experience and imagination.

A patient of mine, a competent and conscientious surgeon, went to the operating room despite knowing that he had a clinical condition with high probability of having deep venous thrombosis and a subsequent pulmonary embolism. Both the preoccupation with his illness and hypoxemia could have been significant. He and the patient were lucky, and there was no adverse outcome. Only after hospital admission for pulmonary embolism did he acknowledge his “bad judgment” in operating that day.

“Disruptive” behaviors impair the professional functioning of the clinician and the interdisciplinary team. Some disruptive behaviors are the following: inappropriate humor, loss of temper, inappropriate or abusive language, and nonverbal behaviors such as appearing angry, irritable, unapproachable, or arrogant. These behaviors often accompany impairments described in this module, but may occur alone. The term “disruptive clinician” is nonspecific, and often pejorative. Recent policy changes by the Joint Commission require accrediting bodies to develop and implement policies and procedures for the identification and remediation of disruptive behaviors, lending additional urgency to the topic. When clinicians are disruptive, intervention techniques are similar to those described below for other impairments.

Impairments in communication ability, consciousness, physical functioning or cognitive performance are common. Communication skills can be impaired by everything from earwax to keratitis to dysphasia. Consciousness is affected by medications, intoxication of all kinds, sleep deprivation, acute or chronic illness, or the many varieties of life stress that afflict everyone. Physical functioning varies with specialty: a fractured wrist would be significant in a surgical specialty, awkward in pediatrics, and possibly a mere nuisance in psychiatry. Cognitive performance is affected by everything from licit and illicit drugs and alcohol, insufficient sleep, neurological diseases and psychiatric disorders. Fluctuations in mood and even “normal aging” may impair cognition.

PREVENTION AND MANAGEMENT

Early identification allows for treatment or management of impairments. Resident fatigue is an example of impairment that is being prevented through regulation.

Module 4 describes tactics and strategies that prevent impairments by helping find or restore personal balance within the context of learning medicine and providing medical care.

The sleep deprivation tacitly required by medical training and practice has come under intense scrutiny and is regulated by professional and public agencies because of its documented impact on professional function and lapses in patient safety. At the level of the ward team we are required to notice our exhausted colleagues, insist that they rest, and finish their work for them. These interventions necessitate more frequent “handoffs” that require vigilance to assure continuity of care.

Physical ailments are often overcome with occupational therapy or special devices. Some impairments, for example depression or situational stress, may be more difficult to identify but are effectively managed when diagnosis is made. Regular health maintenance and screening for stresses and impairments through a steady relationship with a primary care clinician facilitates diagnosis and management of these types of disorders.
Check out the video example about resident colleagues providing validation and support for each other, through their common experiences of long and frequent call nights.

**Video exercise:** View this video and reflect upon your own similar experiences. How do (or did) you manage similar difficulties for yourself and others? What are the important personal and systems issues?

---

**SPEAK UP!**

Because impairments risk patient injury, we must intervene whenever we are concerned that a colleague might be impaired.

The ACP Ethics Manual states clearly that “clinicians who are impaired for any reason must refrain from assuming patient responsibilities that they may not be able to discharge safely and effectively...and there is a clear ethical responsibility to report a clinician who seems to be impaired to an appropriate authority.” Statutes vary from state to state, but some states require you, if you observe an impaired colleague, to report the colleague to state authorities, and there may be penalties for neglecting to do so.

---

**Impediments to intervention**

Many obstacles impede the clinician’s urge to support an impaired colleague. Because patient safety is paramount, overcoming societal, professional and internal or personal barriers to reach out to colleagues is essential.

Communication difficulties, issues of power and concerns about shame and loyalty top the list of impediments to both good intentions and the ethical, regulatory, statutory and patient safety imperatives that call for action.

**Lack of skill and experience:** Medical training rarely includes learning skills for helping an impaired colleague. Some senior management courses do include such training, but we often avoid, miss or are even excluded from these discussions. Thus, few of us have either experience or a specific idea of how to proceed when confronted with an emergent situation.

**Unequal power:** Medicine is rife with hierarchies, such as student/resident/attending, young/old, male/female, generalist/sub-specialist, and staff/chief. Even the idea of confronting colleagues in positions of authority about a difference of opinion, much less about issues of clinician impairment intimidates most of us. If you are a student, you may feel in particular jeopardy since you are often in the most junior position (12). Fear of reprisal, perceptions of lack of respect, or painful past experiences impede students.

**Conflicting loyalties/ betrayal:** Sometimes you may be unclear to whom you owe your loyalty. Your actions could seem an act of personal betrayal even in the face of your obligations to the
patient, your program, or your practice. For example, suppose you are confronting or reporting an impaired colleague such as a fellow student or resident. Perhaps you have suspicions about a practice partner with whom you are quite close and share family events and other social times.

**Shame and guilt:** Aaron Lazare (13) has written about the role of shame and guilt in medicine. Clinicians share cultural beliefs with the general population, notably the idea that impairment suggests weakness. Therefore, the inability to perform well for any reason is embarrassing and shameful. As a clinician observing a colleague you may recognize that risk of shame and, perhaps identifying with your colleague, become reluctant to discuss your concerns. When confronted, impaired clinicians often react defensively against the possibility of frailty.

**Boundary issues:** Confronting colleagues who are friends or practice partners about personal issues seems invasive and often seems like a violation of personal boundaries.

**Perfection and medical culture:** The idea that the clinician should be close to perfect fosters collective denial within the culture of medicine, as well as society at large. We can’t be impaired, we’ve jumped Olympian hurdles. As one senior resident put it, “I have slaved and struggled to get here, and I don’t make mistakes!”

Check out the video example about recognizing impairment from fatigue and effectively assisting the colleague.

**Video exercise:** As you watch the video, listen for the obstacles the resident tells her friend about. Imagine what other obstacles there might be for you. How would you suggest she deal with them?

---

**RECOGNIZE EARLY CLUES**

Diminished quality of work is a relatively late manifestation of impairment. In order to intervene early, attend to behavioral cues and clues that might indicate problems.

Early behavioral clues that may be evident to an observant colleague include changes in work habits such as tardiness, missing rounds, absenteeism or failure to complete tasks. Other cues such as lapses into irritability, mood disturbances, social isolation, or abusive language often precede full-blown impairment. Eventually, the quality of work may diminish and be recognized by missed diagnoses, multiple patient or collegial complaints or inappropriate prescribing. Obvious signs of cognitive or motor impairment, such as might occur with a neurological disorder, severe arthritis, or intoxication, should be acted on without delay.

---

**Ethics and attitudes**

Intervention is difficult. Trust that your colleague shares with you a wish to do well by patients
and society. For best results, maintain attitudes of respect and non-defensive responding.

The effectiveness of a conversation with a possibly impaired colleague springs from trusting that his or her concern for patients overrides personal concerns, even when observations suggest otherwise. It requires courage to approach a peer or a senior clinician, whether the situation is fairly clear (slurred speech and alcohol on the breath) or suspected (perhaps from a declining quality of work).

Take the time to talk with supportive colleagues, administration or other professionals and examine your attitudes and potential conflicts about loyalty, shame and perfection. Recall your personal commitment to the overlapping communities in which you participate, including care of individual patients, the larger society and the profession. Remember that the ethics of your commitment to society and patient safety overrides relationships with individual clinicians.

Preparation

Take time to decide how and when to intervene, and who else should be involved. Review principles of difficult conversations, and remember that the conversation will arouse strong emotions for both you and the colleague.

The primary risk of delay is harm to patients, so do not wait for “more evidence” and proceed with intervention as soon as possible following arousal of any concerns, worries or suspicions. A face-to-face conversation is warranted and provides opportunity to both express concerns and offer support.

When definite evidence of error, poor care or repeated problems in teamwork exist, involve someone in a position of authority, regardless of whether you choose to discuss the situation in person with your colleague. Compose yourself, as you would for any “difficult conversation.”

Approach a conversation with an attitude of respect for the effort that medical care demands of clinicians. Your commitment to addressing thorny issues of impairment in an empathic and non-judgmental manner, bolstered by a dedication to respond non-defensively if the colleague reacts badly assures a reasonable if not entirely satisfactory outcome. Acknowledging in conversation the importance of a trusting and respectful relationship and a parallel concern for the colleague’s well-being paves the way for additional conversations, as needed.

Set aside sufficient time - if impairment from drugs or alcohol is likely, morning may be a good time for intervention. Select a private setting. Prepare to respond to denial, guilt or anger. Review the modules on building relationship (module 6), responding to strong emotions (module 13), delivering bad news (module 33) or the corresponding section on bad news in module 35 on discussing unexpected outcomes and errors.

Check out the video example about strategic planning for intervention when an observation of possible impairment involves a senior colleague.
Video exercise: If you suspect a colleague of impairment, how might you seek a trusted colleague for help in planning effective intervention? Whom would you call? How might they respond?

THE CONVERSATION

An opportunity for a conversation with a potentially impaired colleague is not common. Review these examples and practice what you might say.

Although you will find your own words, here are some example openings in differing situations:

**With someone you know well, and with only minor clues:**
"Bill, I need to talk with you about a concern of mine." (a warning)
"We’ve been working together for a long time and I’ve always admired your work." (statement of respect)
"Lately, however, I’ve been noticing......(description of behaviors that you have observed)"
"I’m worried." (statement of concern)
"Can you tell me what’s going on?" (a request)

**With someone you know less well, and with minimal evidence:**
"Dr. Jones, I know we have not worked together much....(acknowledgment of relationship)
"I need to talk with you about something concerning to me." (a warning)
"It is rather awkward because we do not know each other well." (acknowledgment of difficulty)
"When I consulted on your patient yesterday I noticed..." (description of behaviors that you have observed)
"I was concerned about....” (statement of concern)
"Can you tell me what is going on?” (a request)

**With a senior colleague, and with minimal evidence:** "Dr. Thompson, I know you’re the senior (use title)....and I am just a junior staff member...” (acknowledgment of relationship)
"I am really feeling stuck. Can I speak with you?” (acknowledgment of difficulty)
"On the one hand, you are my supervisor. On the other hand, I am also responsible for my patients." (acknowledgment of your personal position)
"I am worried about what is going on tonight.” (statement of concern)
"I am sure I smelled alcohol on your breath” (behavioral description of your observations)
"I am worried about your going into surgery.” (statement of concern)

Check out the video example about a resident confronting the attending regarding possible impairment.

Video exercise: If you have been in a similar situation, how did it go for you? How might you have handled the situation differently?

Concern for impairment with evidence and requiring report to person in authority:

"Dr. Y, I am afraid I cannot handle this on my own, and I am also responsible for my observations. I need to speak with the Chair about this situation. I hope you can
Speaking to the person in authority:

"Dr. X, I don’t know what to do. I have been working with Dr. Y, and I have noticed.....He and I have spoken already and he knows I am coming to you. I need to put this in your hands."

**Dangerous situations**

Some situations pose immediate risk to the patient and require action “in the moment.”

Dangerous situations include an apparently intoxicated clinician, a colleague expressing out of control anger, or a variety of unacceptable behaviors (eg demeaning, racist, sexist, vulgar speech or humor, etc).

These colleagues are impaired in their ability to behave in a professional manner, although not all of the individuals are “impaired” in a medical or psychiatric sense. The result is the same: the witness or witnesses become aware of dangerous behavior and need to intervene immediately by making a clear statement of what they observe, the perceived danger and what needs to happen at the moment. The nature of the concern, for example, immediate patient safety, group or individual safety/integrity or safety of the protagonist guides the statement that is made.

You may feel worried, frightened, offended, angry, shut down, or “merely” very uncomfortable. When you are clear that “something must be done”, ask for the assistance of someone who is present, or, if alone, speak up.

Although you will find your own words, here are some example openings in differing situations:

**With a patient in danger:**
To Dr. T (who appears intoxicated or otherwise impaired) and Dr. J (team member):
"Can you help me? I am very unsure this case is going well. I need to check with both of you before we go any further."

**When physically or personally threatened:**
To Dr. T (who seems impaired, at least momentarily):
"Dr. T: "Your language really bothers me. I need you to lower your voice and stop using vulgar language."

**Example: A complex intoxication.**
A group of residents and fellows became aware that their attending appeared to have altered consciousness and mentation suggestive of intoxication or another acute organic brain syndrome. After brief questioning of their attending, they spoke quickly to each other, firmly took the senior clinician by the arms and brought him to the ER. In the ER he was discovered to be intoxicated with a psychoactive drug, and later diagnosed as having a chronic dementing disorder, previously unrecognized.

**Example: Getting help, and comprehensive assessment and intervention.**
You may need to obtain prompt assistance in assessing or intervening, and immediate help can usually be obtained from colleagues, senior residents or nurses present or nearby. The imperative is to act - with or without help.
More comprehensive actions include calling on program directors, department chairs, deans for education and/or members of clinicians’ wellness committees or risk management departments.

AnnotatedVideo (not shown in print-out text)
INTERACTION WITH RETURNING COLLEAGUES

When a colleague returns to work, do not ignore your relationship. Initial interactions may feel awkward, but “be yourself,” express interest and show respect for complex feelings related to reentry.

People with impairments may require absences from work to participate in treatment. Talking with someone who returns from hospitalization for cholecystectomy may be easier than if the illness is prostate cancer or breast cancer, with the very personal sexual and gender issues as well as the uncertainties attendant to cancer treatment. Even more problematic are diagnoses such as depression, substance abuse, or neurological problems like stroke or multiple sclerosis.

These ordinary, common and typically human dilemmas call upon you to communicate in a genuine way, on the one hand not being intrusive or asking too many questions, and on the other hand not ignoring obvious realities. Be welcoming in a manner consistent with your own and your colleague’s emotional styles. It is natural to engage right away in clinical and work-related dialogue, because these conversations constitute the foundation of collegial relationships. However, do not fail to recognize that relationship and trust must be rebuilt on a revised foundation - express interest in the person’s health and inquire about feelings regarding reentry to the work force. If your colleague wishes to speak about experiences while away, listen non-judgmentally, and respond honestly and empathically.

CONCLUSION

Colleagues have both an ethical and a collegial obligation to intercede. Patient safety is paramount. Many clinician impairments can be effectively managed.

Numerous obstacles retard and limit the intention to enter dialog with potentially impaired colleagues. These include the “culture of medicine,” role ambiguity, power differences and hesitation to initiate conversations with which we have little experience or practice. Further, we can anticipate the bilateral arousal of strong emotions and a threat to the continuation of a collegial relationship.

However, these situations are part of the human condition and not exclusive to medicine. Nourish and sustain an attitude of commitment to the well-being of the colleague and that person’s patients. Take prompt action. Provide an accurate description of behaviors you have observed. Make explicit statements of respect, personal concern and partnership. Respond non-judgmentally and non-defensively. If possible, review strategies for initiating conversations that might prove “difficult.” Seek timely consultation with trusted teammates such as senior clinicians, department heads and members of the administration, particularly when the danger to patients or your colleague appears imminent.

BEHAVIOR CHECKLIST

- Initiate conversation even if cues and clues leave room for doubt about impairment
- Speak respectfully and non-judgmentally
- Acknowledge the relationship
• Acknowledge the difficulty of broaching this issue
• Express personal concern and state your personal position
• Describe your observations using behavioral terms
• Seek assistance if harm appears imminent for a patient or your colleague
• Welcome colleagues returning from treatment with honesty and respect

REFERENCES

12. Lazare A. Shame and humiliation in the medical encounter. Arch Intern Med. 1987;147(9):1653-8

RESOURCES and WEBSITES:

• Federation of State Clinician Health Programs (www.fsphp.org)
• American Foundation for Suicide Prevention (www.afsp.org)
• Center for Personalized Education for Physicians (www.cpepdoc.org)
Welcome to DocCom Module 40: "Giving Effective Feedback: Enhancing the Ratio of Signal to Noise"

by Burton J. Landau, PhD

© 2005-2014 by AACH, DUCoM, and others. See copyright info for details

Facilitator Guide of this module for doc-com Residency Doctoring Curriculum

Credits:

Authors: Burton J. Landau, PhD
Editors: Dennis Novack M.D., Bill Clark M.D., Ron Saizow M.D.
DocCom implementation: Christof Daetwyler M.D.
Medical Residents: Allison Ferris, M.D., Nimish Patel, M.D., Salish Patel, M.D., Jessica Most, M.D., Albert Hicks M.D.
Video Director and Producer: Christof Daetwyler M.D.
Video Camera, Light and Sound: George Zeiset B.A.
Video Assoc. Director: Dennis Novack M.D.
**Rationale**
Burton J. Landau, Ph.D.

Professor of Microbiology and Immunology,
Associate Dean for Medical Education
Drexel University College of Medicine

**The Intern's View**

**The Doctor's View**
In this video, Burton Landau PhD, Professor of Microbiology and Immunology, plays the role of a clinician responsible for supervision of 3rd year medical students on a medicine clerkship.

**Questions for Reflection:**

1. Think about feedback you have received as a learner.
   - What features of the feedback made it helpful to you?
   - Were there aspects of the feedback that were unhelpful, or left you feeling resentful?
   - What made it so?

2. What are your personal strengths that will enable you to give effective feedback?

3. What fears do you have that may get in the way of offering effective feedback?

4. If a learner irritates you, how might that effect the feedback you offer?

5. After giving feedback, what do you hope the learner will be thinking and feeling?

**Key Principles:**

1. Effective feedback from faculty and peers facilitates improvement and learning
2. A safe and effective culture of feedback includes the following features:
   - agreement on learning goals
   - consensus about expectations
   - direct observation of behaviors
   - consideration of emotions
   - checking learners' understanding and commitment to continued improvement
   - invitation to reflect on potential personal and system resistance to utilization of feedback

Learning goals:

At the conclusion of this module, you will be able to:

- Describe characteristics of a learning environment that facilitates and encourages feedback.
- Describe general feedback principles.
- Describe the problems associated with giving effective feedback and how to overcome them.

INTRODUCTION

Specific elements in the environment of medical education facilitate the giving and receiving of constructive feedback between faculty and learners. You can help to create a culture in which feedback signals are expected, valued and easily heard above the incessant background noise of clinic, classroom and hospital.

A large body of medical education literature attests to the importance of giving effective feedback. (1) Ende, in a seminal article on giving feedback in the clinical setting (2), emphasized that feedback should address changing behavior rather than changing the person exhibiting the behavior. Learners at all levels desire and appreciate feedback. (3, 4, 5)

For purposes of this module, “feedback” is a strategy employed by teachers and coaches to enhance the learning of their students or trainees. Feedback is directed towards improvement. On the other hand, “positive reinforcement” is acknowledgement of behaviors that are at least satisfactory. Key elements of effective feedback include a focus on future performance, good intentions, accuracy, and timeliness.

In an often hectic environment, you can give better feedback and become more alert to feedback you receive if you attend carefully to maximizing how feedback is heard (the signal) and minimizing background (noise). Creating a learning environment in which constructive feedback promotes learners’ willingness to try different approaches to problem-solving, knowing that you will note errors and give advice for improvement.

This module will focus on general feedback principles, optimizing learning environments and emotions about feedback.

GIVE FEEDBACK ABOUT OBSERVED BEHAVIORS
Effective feedback focuses on improvement and addresses behaviors that ought to be changed. Optimally, the feedback derives from personal observation of behaviors and skills.

**Focus on future performance:**

Feedback is directed towards improvement. It involves formative assessment of a specific behavior and a plan that, if implemented by the learner, will result in a favorable outcome. Giving feedback effectively involves judgment and skill. Failure to give feedback conveys a number of possible messages, ranging from, “No improvement is necessary,” to lack of instructor interest, or even instructor inability to provide feedback.

**Observations, even-handedness:**

Feedback is most effective when it is based both on personal observation (insuring accuracy of assessment that prompted the feedback) and its relevance to the learner’s goals. Learners are particularly appreciative of instructors and peers who are even-handed, i.e. giving feedback when improvement is needed and acknowledging (positive reinforcement) actions done well. Commonly, you give feedback verbally or in writing, but you also convey feedback by non-verbal cues such as posture and facial expressions.

---

**ESTABLISH EXPECTATIONS**

Clarify and agree on expectations so that learners know what they are to achieve, and give feedback in a timely way.

**Establish consensus as to mutual expectations:**

In an optimal learning environment you, as the instructor, will describe the behavior that you expect from learners and let them know that you will provide both formal and informal feedback. If you expect learners to demonstrate or master specific skills or tasks, outline them in detail, using handouts and skills checklists with anchoring statements, so that learners will know what they must achieve. Then, check that they understand your expectations. Formal feedback is accomplished in scheduled sessions and meetings, so that learners can reflect on the feedback and act upon it before you make a final (summative) evaluation. Informal feedback, occasionally not thought of by learners as “feedback”(7) can occur anytime. Encourage learners to reflect on the feedback so that they can internalize it, process it, and make it part of their total learning experience. (8)

*Please click the video-button on the left and watch the vignette "You must fix this - NOW!"*
Timeliness:

Feedback is best given as near as possible to the observations you make. Otherwise, both learner and instructor lose some relevant details, and learners are likely to be distracted by intervening events, thus greatly reducing the value of the feedback.

ADJUST FEEDBACK STRATEGIES

Learners appreciate feedback given straightforwardly, succinctly and objectively. Nuance your feedback by checking its impact, and consider learners’ vulnerability about communication skills behaviors.

Adjust to situation and learner:

Calibrate and deliver feedback with proper attention to the learning situation. In general, non-emergent issues should be dealt with in non-emergent terms. In most situations, feedback requires no drama, since you are focusing on behaviors, not the person. Some learners need more information from their instructors and peers than others. Check with learners to establish the impact of feedback, and do not deliver more than they can digest. Some learners are easily overwhelmed, particularly if the feedback concerns a behavior that they already have been working to change, unsuccessfully. Keep your feedback free of personal references and deliver it in unemotional and objective terms. The art of giving feedback involves recognition that there are many ways of delivering feedback and the skillful instructor chooses the way most appropriate for the learner and for the occasion.

Feedback about communication skills:

Receiving feedback about communication skills often puts learners in a more vulnerable state than in other learning situations. They’ve been communicating all their lives. Even well-intentioned and well-constructed feedback delivered compassionately may be taken to mean “you are not good enough”, or “you should know better.” In this latter situation, learners often feel personally attacked, criticized or ashamed that they cannot do a “perfect” interview or demonstration the first time. You can emphasize that you don’t expect perfection and that getting feedback hastens the process of mastering skills and strategies for use in unfamiliar, unanticipated and unsettling situations every clinician encounters while caring for patients and their families.

OPTIMIZE LEARNING ENVIRONMENTS

Learners expect feedback and value faculty and peers who offer appreciation of things well done as well as suggestions for improvement.

Establish culture of feedback:

In a study that examined the characteristics of faculty judged by learners as skilled in giving feedback (6), the authors found that these skills included a willingness to consider the emotional response of learners, an ability to resolve conflict, an interest in determining what the learner wanted to get out of the experience, a willingness to establish consensus as to mutual expectations, and a willingness to allow learners the time needed for them to solve the problem on their own.
Make feedback part of the learning culture. In this instance, all students expect suggestions for improvement as well as acknowledgment of what was done well. In the latter instance, for example, comments from supervisors commending a student’s performance need not be effusive. Often, a “well done”, or a smile of approbation is all that it takes to make a learner’s day.

**Self-assessment:**

When giving feedback, a useful strategy is to ask learners to self-assess, and to inquire about what they think is an appropriate next step on the road to improvement. This helps you determine their level of insight about their ability and their comprehension of reasonable next steps. After learners’ self-assessment, you can offer your own assessment and recommendations for future improvement.

**CONSIDER EMOTIONAL RESPONSES**

Expect that you and your learners will sometimes be feeling embarrassed or inadequate, shy, overconfident, irritated, disinterested or unmotivated. Singly, in groups and with peers, include talk about feelings when such conversation will advance learning.

Discuss with learners that your feedback is meant to be helpful, formative, and designed to produce a positive summative evaluation. Remind them that they are adequate as persons and as learners, but that developing a toolbox of effective skills is a challenging task that will continue throughout their professional careers. Practice is important to skill development, and some skills are inherently more complex or difficult and will require more practice than others.

Inevitably some learners take feedback personally, often feeling invalidated, or that they are not good enough. These feelings usually reflect the learner’s broader issues and feelings about themselves in relation to the course work or clerkship. It is an opportunity for you to respond with empathy, and perhaps to inquire in a nonjudgmental fashion about what might be going on, and what is getting in the way of learning.

**Feedback in Groups**

Self-esteem may be even more fragile in group settings. Do not make irrelevant positive comments to soften feedback.

Another challenge involves giving feedback to a learner in the presence of peers in such a way that you preserve the self-esteem of the feedback recipient. As learners in the group notice that you attend thoughtfully to preserving the self-esteem of the feedback-recipient, the entire group is reassured that whoever is next will not be embarrassed or worse when they are the recipients of feedback.

Trying to soften the impact of feedback by prefacing it with irrelevant positive comments is of little value. Learners quickly begin flinching as soon as they hear a positive comment because they fear that the next comment will be about something they have done especially poorly.

**Feelings in those who give feedback**
Noticing and reflecting on the feelings associated with giving feedback improves teaching and learning.

A willingness to give feedback involves taking risks, whether you are designated a “faculty” person or you are a peer of the feedback recipient. These risks include being unpopular, becoming involved in a confrontation, making incorrect or incomplete observations, working under time pressure and sometimes failing to explicitly acknowledge excellent progress or appreciate major deficits.

Giving constructive feedback when stressed or angry is difficult and the results uncertain. Unless there is an immediate need, feedback is best delayed until tempers have cooled. In some cases, it is advisable to deliver the feedback in writing rather than verbally. Document the facts and deliver your recommendation for improvement as dispassionately as possible.

Sometimes it will be helpful for you to disclose and acknowledge with your learners your feelings about your emotional responses to the stresses of giving feedback. Reflecting on both facts and feelings about the feedback aspects of your teaching activity with faculty peers improves the quality of future feedback to learners.

ASSESS FEEDBACK EFFECTIVENESS

Develop strategies for discovering the overall effectiveness of your feedback activities.

Perhaps one of the greatest challenges facing faculty is finding out whether the feedback received was helpful. One way is to ask the learner what he or she has taken away from the feedback, and what he or she will do differently, and when. Another direct way is by observing improvement or conversely, its lack, in the learner’s behavior. Alternatively, learner surveys or focus group sessions may yield information concerning the issues discussed in this module. These include the manner and timing of the feedback, the appropriateness of the feedback and recommendations for improvement and whether the feedback is given in a professional manner, i.e. free of bias, objective, positive and future-oriented.

RESIDENTS ARE FACULTY

The team’s supervising resident is in closer and more frequent contact with team members than any other faculty member.

Drexel University College of Medicine residents and faculty brainstormed and refined their perspectives on the role of Resident as Teacher. We present their lists of helpful Principles and key Strategies for improving the learning environment and the entire team’s learning opportunities.

Resident Principles for Creating an Optimal Learning Environment

Resident team leaders’ effectiveness as teacher, supervisor, role model and advocate depends on their communication skills and attention to all team members’ feelings.
1. **Golden rule: Treat your interns the way you would want to be treated!** They are equal colleagues--do not look at them as subordinates, and remember, you were in their shoes only a short time ago. You and your interns are a team. If you can look at each other in that way, your patient care becomes more effective and efficient. (Sometimes interns have done residencies in other countries and have considerable experience. Be open to learning from them.)

2. **Residents have an obligation to teach,** both interns and medical students. Take time to consider how you can be an effective guide, and spend your extra time preparing to teach. Teaching can be both academic and practical. (Examples of practical points: How to work with talkative patients, how to respond to family members’ concerns, how to decrease patients’ hospital stays, how to prioritize clinical tasks, time management in general, the “ins and outs” of the system.)

3. **Communication is key.** Keep the lines of communication open with your intern and students. If you are unhappy with how some things are going, set aside time to explore the issues and “clear the air,” since resentments undermine team dynamics. Remember that you are an authority figure, so your interns may feel reluctant to bring up issues or be assertive about their needs. Encourage them to talk about how things are going for them and what they need from you.

4. **Perfection is the enemy of the good.** You don’t need to be perfect, or expect your interns to be perfect. Saying “I don’t know the answer to that, let’s look it up” or, “I’m not comfortable managing this problem, let’s get a consult” can be reassuring to your team members and set a good example.

5. **Provide positive energy!** Your positive attitude and enthusiasm make a real difference in the team.

6. **You are a role model and a mentor for your team.** Your interactions with patients, colleagues and staff set an example of professional behavior. Also, you have been through a lot during your internship, and the lessons that you can pass on will help. You remember that internship is very stressful. Interns make mistakes. If you are supportive, positive and understanding, your attitude will reduce anxiety and help interns learn.

7. **Monitor your own feelings and mood.** Leaders who are irritable and easily annoyed create a negative learning environment. If you are feeling down, talk to a colleague or consider getting help. You cannot be effective with patients and your team if you don’t take care of yourself. Also, be sensitive to your intern’s emotional state. Up to 30% of house staff become burnt out or depressed and this may put the team off balance. If your intern is down, or dragging, gently inquire, and offer help. “I notice that you seem (a little down; irritated; etc.); would you share a little about what is going on--I’d like to help?”

8. **Be an advocate for your team.** As team leader, at times you will need to protect your team members from inappropriate demands. Also, take responsibility for the team, and if for example, the attending asks about something that hasn’t been done, don’t blame the intern!

9. **“Think about what’s best for the patient, not about yourself, and you won’t go wrong.”** (Edgar Sanchez) In a way, this seems like an obvious principle but sometimes it gets lost when a fellow or attending seems annoyed when you call in the middle of the night. You or your intern might feel intimidated to call because of a superior’s negative reputation, or you may not want to ask a question for fear of being criticized or that others might think less of you. If you can keep the perspective that we’re here for the patients first of all, and the potential blows to our self-esteem are small when compared to the patients’ needs for us to care for them, you’ll do what is right.
Resident Strategies for Creating an Optimal Learning Environment

Reach agreement with team members about expectations for sharing work, making time for learning, taking responsibility and the nature of teamwork.

1. **Clarify goals and expectations** at the beginning of every rotation with your team. Setting high expectations is usually helpful. Be clear on the details of everyone’s roles, including your own. Tell interns to call you right away if a patient takes a turn for the worse. Talk to interns about how to organize and prioritize their days. Ask them about their system and make suggestions to improve it. Help interns understand the “long view” of the rotation, since interns tend to get caught up in the minutia of daily tasks and lose perspective on their general patient care and learning goals. Tell interns the rules about new admissions. (For example, when is it ok for triage to give you new admits, etc.) Be open to suggestions. Look at the first day as a team building exercise. Get to know each other. This sets the tone for the whole rotation. Ask your intern how they learn most effectively. What are their expectations and learning goals for this rotation? How can you help them achieve those goals? Do they learn best with a lot of guidance, or do they want to work independently and call you when they need you? Come up with an explicit agreement about how you will work together during the month.

2. **Work as a group.** If you share the work, there will be more time for teaching, (and for much needed breaks). Consider setting goals as each day begins. Help interns manage their time and work more efficiently—at first, help interns prioritize tasks since everything seems important in the beginning. In the first months, ask the intern how many notes they can write by 10AM and call them at 10AM asking, “who have you seen and what do you need me to do?” At the end of the day, consider sitting down to go over what we all did today, and think about what the team will need to accomplish tomorrow.

3. **Be available,** and make sure your interns know you are available. Show up when needed. Don’t teach over the phone.

4. **As role model and mentor,** follow these guidelines:
   - **Let interns know you support them,** respond graciously to questions and invite them to ask whenever they are not sure of something. Your empathic leadership fosters their growth and enhances team effectiveness.
   - **Find things that are going right,** and compliment your interns, in addition to looking for things that are wrong and correcting them for the future. Appreciate their accomplishments, both in patient care and learning.
   - **Never talk in a disparaging manner** about other house staff. Your gossip begets additional gossip and inevitably creates a negative tone. Also, gossiping contributes to creating false impressions that could follow people for a long time.
   - **Are you making a positive contribution** to the program? Your words and actions contribute to the general culture of learning in the residency.

5. **Plan for mid-rotation informal feedback,** and articulate what that feedback will cover. (This feedback session will be something like going to coffee with your intern(s), asking them how things are going, are they accomplishing their stated goals, asking how can we do better, what could I as the resident do differently that will help the team, etc?)

6. **You are responsible** for the care of patients on your team. This means that you should have a goal of seeing every patient every day! For the sicker patients, you need to spend time and make sure all bases are covered. For the less sick patients, you can spend less time. You should review all patients’ labs every day.
7. **Set aside learning time**, perhaps 15-20 minutes in addition to attending rounds. Every day, pick something from your patient panel: a physical finding, a feature of a patient’s disease that you can explain more fully. At the beginning of the year, a good teaching session would be “common calls that an intern will get, and how to respond to them.” (This session would also be good at the end of the year for the fourth year students.)

8. **Organize a 20 minute team orientation** with a Fellow for specialty rotations, like at the beginning of MICU, CCU, or oncology rotations. Make it a short overview of what is expected and perhaps create or locate handouts of essentials unique to that specialty – adjusting vent settings in MICU, interpretation of swan readings and how to make management adjustments based on these in the CCU, how to respond to a febrile neutropenic patient in oncology, etc.

9. **Bring coffee or make other simple gestures of support** occasionally for your post call interns. Your encouragement and support are reassuring and help your interns maintain a positive attitude.

10. **Attend to communication** with other patient care team members. You can explore many communication issues, like how to respond to “suggestions” from nursing staff without being confrontational. Listen to nurses and be respectful in talking with them. Don’t get to the point of yelling at a nurse or colleague. Work at being assertive and respectful at the same time.

11. **When acting as resident for a sister team**, help your post call intern. Be certain that each of you is finished with your work before you leave the hospital on weekends.

---

**CONCLUSION**

Providing feedback is both a skill and an art. It involves accurate assessment of an action or behavior that needs improvement and feedback that includes a plan which, if followed, will facilitate the learner’s ability to achieve the desired goal. At the same time, learners receive and process feedback in different ways. The art of giving feedback involves knowing when and how to employ the most effective strategy to address the needs of individual learners.

**BEHAVIOR CHECKLIST**

1. Reach agreement that feedback facilitates improvement. (Establishes a feedback culture and creates a safe learning environment.)
2. Note that feelings of exposure and embarrassment are normal.
3. Establish agreement about what the “correct” behavior looks like.
4. Personally observe behaviors for which you provide feedback.
5. Invite self-assessment by learners.
6. Appreciate good work as you begin feedback.
7. Suggest improvements.
8. Check learner understanding of suggestions.
9. Check commitment to continue working to improve this skill.
10. Focus on behaviors (not personality or character traits or attributes).
11. Respond with empathy to verbal and non-verbal expressions of emotion.
12. Invite reflection about both instrumental and emotional obstacles to acceptance of feedback and commitment to improvement, both in the moment and outside the learning session.
13. Conduct informal and formal evaluations of the effectiveness of feedback you give.
ADDITIONAL VIDEO EXERCISE

Watch the Vignette Videos, then consider the following questions, in light of the BEHAVIOR CHECKLIST for this module:

Please click the video-button on the left and watch the vignette "Midterm Feedback"

Questions:

1. Does this “too kind” faculty member give effective feedback?
2. Does he further the student’s learning?
3. Does he provide suggestions for improvement?
4. Do you think the comments about Wegener’s (“great”, and “I would not have expected a 3rd year to come up with that”) will advance Allison’s growth and learning?
5. How does he respond to Allison’s feeling of confusion about physical findings and presentations?
6. Does he invite reflection or commitment to further improvement?

VIDEO (not shown in print-out text)

Role play

This role play of an Intern giving feedback to his Resident is based on a true occurence
Role-players: Jessica Most, M.D. (Resident), and Albert Hicks M.D (Intern)

References

2. Ende J. Feedback in clinical medicine. JAMA 1983;250:777-781
5. Busari J, Weggelaar N, Knotternerus A, et.al.. How medical residents perceive the quality of
supervision provided by attending doctors in the clinical setting. Medical Education. 2006;39:696-703.


Questions for Reflection:

1. What elements distinguish a professional relationship from other human relationships such as friendship, family or that between colleagues or classmates?

2. In your professional relationships to date (as clinician or as patient or as family member of a patient,) have you been aware of situations when the professional person responded in ways that did not seem appropriately “professional” (perhaps by behaving in too social or friendly a manner, or perhaps by seeming too distant or abrupt)? How do these experiences inform your sense of “professionalism”?

3. In a clinical situation, what principles might be useful in deciding how to respond to gifts you
are offered from patients, or to a possible “come-on” from a patient, or to patients’ questions about your personal life?

4. Have you encountered situations in which your professional boundaries became an issue? How did you decide what actions to take?

5. Personal issues play a role in clinician’s behaviors in regard to professional boundaries. How do the following issues apply to you?
   - To what degree do you take responsibility for the happiness and well-being of your patients? Of your family and friends?
   - To what degree are your interactions with patients meeting your own emotional needs?
   - How comfortable are you in saying "no" to patient requests?
   - Are you prone to "rescue fantasies" in your care of patients?
   - Do you often take care of the needs of others before your own?
   - What were the attitudes and behaviors about boundaries in your family of origin?

**Key Principles:**

1. Boundary-challenging interactions are those in which optimal professional action is unclear, often because the distinction between social and professional behavior is hazy.

2. Every clinician is confronted with boundary-challenging situations such as gift-giving, self-disclosure, physical touching, social invitations or social encounters with patients.

3. Problem-solving requires clinicians to reflect on the value of altruism, consider patient and clinician motives, take into account inherent power differentials, seek consultation, and to err on the side of firm boundaries.

4. Communication about boundaries should convey respect for patients’ feelings as well as acknowledge the complexity of the situation. Consider making statements about ethical and professional standards, statements that clarify the professional nature of clinical relationships and statements that indicate a need for additional time to consider the situation.

**Learning goals:**

At the conclusion of this module, you will be able to:

- Describe ‘boundary-challenging’ situations that clinicians commonly encounter.
- In individual and group settings, reflect on appropriate boundary limits for clinicians in general and yourself personally.
- Describe strategies for deciding how to respond to commonly encountered boundary-challenging situations.
In boundary-challenging situations, demonstrate ability to compassionately appeal to professional standards, state a general principle to which you adhere, clarify the nature of the relationship, or postpone a decision.

**PROFESSIONALISM AND PROFESSIONAL BOUNDARIES**

The clinician-patient relationship requires a special kind of intimacy. Caring and warmth must be shared within mutually understood professional boundaries, and ‘boundary challenges’ arise regularly in clinical practice. Awareness of these challenges and responses to them that are simultaneously human and professional require mindfulness and practice.

The introduction section of this module is outlined as follows:

- Intimacy and professionalism; **concepts** of boundaries and limits
- Social and professional behavior norms; **discernment** and “alarms”
- Responding to alarm signals; **principles** for examining and resolving challenges
- Communicating: **strategies** for responding to boundary challenges
- Communicating; **skills** for responding to boundary challenges

**INTIMACY AND PROFESSIONALISM**

Healing relationships involve trust, esteem, love and caring, which must be bounded by professional commitment to accountability, altruism, respect, confidentiality and self-care.

In this module, we explore the boundaries of a particular form of human relationship – the doctor-patient relationship. This relationship is often an intimate one, in which trusting patients confide their most personal issues as well as their fears, hopes and dreams. Patients often esteem and love their clinicians, and we in turn often admire, care for, and even love our patients. This intimacy and caring can be healing elements of our relationships with patients, but only when they occur within mutually understood professional boundaries. The idea of professional boundaries is informed by the concept of professionalism, which encompasses a commitment to altruism, confidentiality, accountability, excellence, respect, compassion, self-monitoring and self-care.

The study of professional boundaries is concerned with **behaviors at the limits** of a clearly defined notion of professionalism. Any beginning medical student knows that it is unprofessional for a clinician to come to work intoxicated, to have sexual relations with a patient, or to prescribe narcotics to a neighbor. You might also easily identify certain examples of professional behavior; such as, a clinician who apologizes for and tries to rectify a mistake, or refuses to share patient information with her spouse.

**Where do you draw the boundary line?**

Clinicians must recognize and resolve ambiguous, uncomfortable and potentially exploitative situations involving gift-giving, attraction, self-disclosure and social relationships.

When we exclude situations that are clearly inside or outside of the **bounded concept** of professionalism, we notice that ambiguous boundary areas remain. Situations shaded in gray...
might include the following:

- Is it ok to accept a gift from a patient?
- Is it appropriate to reveal personal information to a patient?
- What should I do if I know a patient from another context?
- What if I find myself feeling attracted to a patient?
- May I keep in touch with a patient who is no longer in my practice?

Such situations are poised at the top of a "slippery slope" in which the patient or provider are at risk for sliding into an uncomfortable and potentially exploitative situation. Successful negotiation of these and related professional boundary challenges is essential for the development of a trusting and effective relationship between clinician and patient, and ultimately a successful and satisfying career in medicine.

SOCIAL AND PROFESSIONAL BEHAVIOR NORMS

Understand the distinctions between the social norms that govern personal relationships and those that apply to professional relationships.

Professional boundaries might also be thought of as the social norms that govern the clinician-patient relationship. Ideally, social norms serve to maintain order, safety and productivity in human relationships and communities. Think of the social norms you learned growing up. You probably learned not to look at naked people, and certainly not to touch people's private parts unless you were involved in an intimate relationship. You learned not to play with or even discuss body fluids. You learned not to ask people very personal questions about themselves.

These ingrained social norms no longer hold in the clinician-patient relationship, as the new medical trainee breaks one "taboo" after another. This process can be unsettling and confusing to the medical trainee and even the advanced practitioner. Students must learn to internalize a new set of social norms, called "professional boundaries". Furthermore, the clinician must be clear on the distinctions between the behavioral norms that apply to one’s personal or social relationships, and those that apply to one’s professional relationships, and be able to manage the complexity inherent in "dual-relationships."


Discerning boundaries

There are no clear-cut "rules of conduct" for common boundary challenging situations. We offer guidelines and principles to help problem solve and negotiate boundary challenges.

The development of healthy and effective professional boundaries is fostered by opportunities for mentorship, problem solving, and practice with language. Memorizing "rules of conduct" is rarely helpful in learning to negotiate common boundary challenges. This module states some general principles applicable to the infinite variety of challenges every clinician encounters. The movies in this module depict commonly encountered situations containing a "boundary dilemma". They offer rich opportunities for reflection, case exploration, problem solving and role play. These clips depict clinicians early in their training, but the lessons and principles are applicable for every level of medical training and experience. Apply the module's general principles and practice the suggested communication strategies and language, and begin building a repertoire of effective solutions that
Tune into your Boundary Alarm

Certain situations, such as strong emotional reactions to a patient, gifts, or personal questions should trigger an internal "alarm" to warn you of a possible boundary challenge.

In negotiating boundaries in clinical practice, you might find the "boundary alarm" framework a useful conceptual guide (2). The phrase "my boundary alarm is constantly going off!" was coined by a medical student struggling with issues of self-disclosure and social interactions with patients. Like a home security system, a boundary alarm is intended to preserve safety, well-being and integrity. It must be set to ring at the correct threshold - a setting that is too low produces cold and distant relationships; too high a setting may result in unprofessional behavior and unsafe outcomes.

Your alarm should ring and increase your vigilance about boundary issues whenever you encounter personal questions, gifts, hugs, social invitations, chance encounters or business dealings with patients. Further, emotional reactions to patients, such as a strong like or dislike for a patient, or the feeling that you are saying or doing things around a particular patient that you wouldn’t normally say or do are part of our normal human responses to other people, but in the professional setting should definitely set off your boundary alarm. Psychiatrists refer to these emotional responses as counter-transference feelings, acknowledge their power, and assure us that vigilance is especially important in these situations.

Each movie in this module depicts a situation that should trigger your boundary alarm. Your thoughtful responses to the alarm signals are often as important to your patients’ health as any other diagnostic or treatment actions you take on their behalf.


RESPOND TO BOUNDARY ALARM SIGNALS: PRINCIPLES

In this section, we present 6 problem solving principles that can help when you encounter a boundary challenging situation. Internalizing these principles can help you decide what to do and what to say when your boundary alarm rings

- Operationalize altruism.
- Understand patient motives and needs.
- Understand your own motives and needs.
- Remember the power differential.
- Call on colleagues.
- Err towards more boundaries, rather than fewer.

Operationalize altruism
Always consider what actions and words would best benefit the patient.

Altruism is a fundamental distinguishing feature of a professional relationship. Operationalizing altruism involves discerning how to place the needs and interests of the patient before your personal needs. Take the time to ask yourself these questions:

"What action would be in the best interest of this patient?" and,

"What action has the highest likelihood of assuring a successful ongoing professional relationship with this patient?"

Consider what course of action and what words would benefit the patient in the short-run and what might allow the relationship to thrive in the longer-term future.

---

**Understand patient motives and needs**

Discovery of effective resolution to a boundary dilemma requires an understanding of the patient’s motive and purpose.

For example, with gift-giving or social invitations, ask yourself:

"What does the gift or invitation mean to the patient?"

"What is the patient trying to communicate with this gift?"

Let your answer help guide your solution. It is important to try to understand the meaning of the gesture, and to respond appropriately to it, if the relationship is to retain the proper focus on patient well-being. Usually the best way to understand a patient’s motive is to ask the patient. You may have some hunches or assumptions about the meaning, but checking with the patient shows your respect for subtlety, your concern about trust and dignity, and your interest in putting your patient’s well-being first.

---

**Understand your own motives and needs**

Discovery of effective resolution to a boundary dilemma depends on your attempt to understand your own emotions, needs and reactions.

Try to identify what personal and professional issues a given "boundary challenge" raises for you. Pay attention to your own emotional reactions. Ask yourself:

"Am I identifying with a particular patient?"

"Do I find myself disliking a particular patient?"

"Are there potential conflicts of interest in my interactions with this particular patient?"

"How does this make me feel regarding this patient and my medical practice?"

The clinician should be especially aware of how his or her own needs such as the perfectly normal needs for certainty, affection, intimacy, or conflict avoidance may shift the focus of the encounter away from caring for a patient’s illness or health concerns. Pause and consider whether certain possible responses actually serve your personal needs rather than advancing your professional relationship with this patient.
Remember the power differential

Power differentials are unavoidable. Ignoring these differences leaves patients and clinicians vulnerable to unconscious attempts to take power or give it up.

Take into account the power differential in your relationships with patients, and recall that this factor always affects expectations and interpersonal interactions. Whether consciously or not, patients perceive care providers as quite powerful. Medical trainees may not realize how patients perceive this issue or how strongly patients respond to it because of the trainee’s relatively low status in the medical hierarchy. Seasoned clinicians often discount the extent to which the power differentials and the patient or clinician’s unconscious attempts to cope with them may lead down slippery slopes toward invitations, gift-giving and so on.

Call on colleagues

Gain important perspective and new ideas, and also assist your colleagues’ growth by calling them into conversation and seeking advice.

Bringing underlying issues and emotions to light and discovering sensible solutions is always easier when we enlist help from someone not directly involved or affected by the situation. Obtain supervision from a trusted colleague or call on a mentor for consultation when presented with a boundary challenge. Ask:

"Have you encountered experiences like mine?"

"With the advantage of hindsight, what are your thoughts now about it?"

"What if you were in my shoes, what would you think and do?"

Further, because boundary issues are so common and puzzling, your request is also likely to improve the colleague’s awareness and understanding of future issues that he or she will confront.

Err towards more boundaries, rather than fewer

When uncertain, always take actions that you anticipate will provide safety and increase trust, even though you may feel more distance in the relationship than you’d like.

Remember that relaxing a more rigid boundary is easier than back-pedaling up a slippery slope! Once a safe, trusting relationship is firmly established and boundary challenges clarified, you can always adjust the limits of the relationship.

COMMUNICATION WHEN CHALLENGES ARISE: STRATEGIES

When the boundary alarm rings, experienced clinicians have a repertoire of effective types of responses to call upon while they seek to better understood the nature of the issue. Use the following communication strategies when you encounter a boundary challenge:
Appeal to medical ethics or professional standards

Advise patients that you structure relationships in accordance with professional guidelines from groups to whom you are accountable.

Patients are helped by hearing you speak about professional standards and guidelines for maintaining professional relationships. Let them see that you understand your clinical relationships to be professional ones, with boundaries that you will honor.

"I'm sorry, it's against the Board of Registration Guidelines for me to write a prescription for someone who is not my patient" or, "It's not considered a medically ethical practice to ____"

Appeal to general principles

Let patients know that you’ll relate to them according to the same norms and principles that you guide your interactions with all your other patients.

Help your patient see that your actions about an issue are general principles by which you operate rather than special actions taken because the patient is special in some way—that is, "It's not personal." You might say something like the following:

"I have a rule" or, "My practice/view/belief is _____, so this action (or these words) is what I do (or say) whenever this comes up with a patient."

Reiterate the nature of the relationship

Remind patients of your awareness that professional relationships have particular limits and structures.

Remind patients of your awareness of the professional nature of your relationship. You could say:

"Sometimes it can be complicated for a caregiver to interact with a patient outside of the medical setting. In that situation, it might color my judgment about what’s best for you medically, or could interfere with your willingness to disclose uncomfortable experiences ..." or,

"As a medical student working with your primary care clinician, I'll need to defer to her on that issue."

Take the time you need to consider an issue
Reassure patients that your relationship with them is important enough to require special consideration.

The clearer you can be about your concern about keeping relationships properly oriented, the more cared for your patients will feel. Show how important a professional approach is by asking directly for time to reflect on the issue. Simple and direct statements are helpful. Consider saying the following:

"I'll need to think about that" or,

"I'll need to consult my preceptor on ___"

COMMUNICATION WHEN CHALLENGES ARISE: TACTICS AND SKILLS

Each of the following text sections presents a specific common, predictable and recurrent dilemma, and is associated with a movie clip.

In turn, go to each text section, view the film and reflect on possible answers to the questions. Think about what the clinician or student should say or do in the particular scenario. The texts and movies present the following dilemmas:

- **Self-Disclosure**
  Clinician self-disclosure may contribute to establishing a healthy partnership with a patient, but always consider whether or not your personal disclosure will benefit the patient.

- **Gift-Giving**
  Gifts may powerfully affect the giver and the receiver. Do not accept gifts unless examination of purpose and potential effect shows that their acceptance is in the best interest of the relationship.

- **Social Invitations from Patients**
  Every professional interaction has a social component and satisfies normal needs for human connection. The decision to socialize with a patient requires that you first clarify the limits and nature of a ‘dual relationship.’

- **Clinician-Patient Touch**
  Clinician-initiated touch should be limited to sanctioned physical examination techniques and simple comforting gestures.

Clinician self-disclosure

Clinician self-disclosure has pros and cons. It may contribute to establishing a healthy partnership with a patient, but always carries risks. Self-disclosure that seeks friendship, caring, sympathy or intimacy from a patient is a boundary violation. On-line self-disclosure is problematic these days, whether directed to a patient or other sites. (3,4,5)
The vignette “What about you, Doc?” stimulates at least the following questions:
1. How did the clinician end up in this situation?
2. What are some possible advantages and disadvantages of clinician self-disclosure in the doctor-patient relationship?
3. How would you respond?

The guiding principle in deciding whether to self-disclose is altruism. To put altruism to the test, ask yourself: “Is self-disclosure in this patient’s best interest? Will disclosure strengthen the professional relationship?”

Self-disclosure is problematic if it is automatic, gratuitous or done in an attempt (however unconscious) to seek care or sympathy from the patient. Also, a patient may perceive disclosure of personal information as an offering of friendship or mutual interpersonal intimacy which the clinician does not intend. Self-disclosure risks heading down a “slippery slope” from which backpedaling is difficult.

Possible advantages of self-disclosure include establishment of rapport, and perhaps minimizing the inherent power-differential in the doctor-patient relationship. Some evidence suggests that clinician self-disclosure around personal behavior can motivate patients to adopt better health habits, specifically diet and exercise. Writers disagree on the appropriate depth and content of clinician self-disclosure. Beach notes the complexity of self-disclosure communication, and declares that a mindful awareness should balance spontaneity.

If you notice that you are spontaneously talking about yourself to a patient, you should explore your own motivations. Are you bored? Is this an attempt to get the patient to like, admire or take care of you?

The primary goal should be to maintain the focus of the interview on the patient and his or her wellbeing. If a patient asks you a personal question, consider why this particular question has arisen at this point in time. Is it an attempt to “make friends,” simple curiosity or an attempt to seek reassurance? Sometimes patients are interested in how your experience might relate to their own issues. For example, patients who have problems with their teens may ask if you have had teenage children. Your own similar experiences might in fact help you to understand and empathize with their
situation, but you must still weigh the potential impact of such a revelation. Whether or not you disclose in response to a patient’s question, your words should redirect the interview to the patient. Language such as “I’m really interested in your experience with …..” can refocus the interview and lower the likelihood that the patient will feel rejected in the conversation.

Self-Disclosure and On-Line Social Networking

On-line social networking poses additional challenges to maintaining safe and effective professional boundaries.

Social networking sites such as Facebook are specifically designed for disclosure of personal information, including videos, photos and descriptions of activities and feelings. Such information may be easily disseminated despite thoughtful privacy settings. On-line social interactions between clinicians and patients are high-risk interactions, and promote unintentional self-disclosure as well as widespread dissemination of private information. Guseh and Brendel suggest the following guidelines (paraphrased) for use of social networking sites:

- Do not initiate an invitation to a patient to become an on-line friend, and think carefully before accepting a patient's friend request. The clinician should consider engaging in a face to face discussion with the patient about the potential implications and/or risks of an on-line 'friendship', or might consider seeking an ethics consultation prior to accepting a patient's friend request.

- Do not enter into the medical record any information obtained on-line, unless the patient explicitly agrees.

- Medical trainees and clinicians must exercise judgment and restraint prior to disclosing personal information on the internet. Content, tone and professional decorum should be carefully considered.

- Understand the privacy settings of any on-line social networking sites, and use conservative settings. Keep in mind that privacy technology is imperfect.

Gift-giving

Gifts may powerfully affect the giver and the receiver. Do not accept gifts unless examination of purpose and potential effect shows that their acceptance is in the best interest of the relationship. (6,7,8)
The vignette “Thank You!” stimulates at least the following questions:

1. What motivates the patient’s daughter to give the gift?
2. What else might motivate a patient to give a gift?
3. What are the pros and cons of accepting a gift (in this case, and in general)?
4. What should the student do and say?

Whenever you receive a gift from a patient, ask yourself: “What does this gift mean to the patient?” A small token of gratitude might be accepted with a simple “thank you”. A presumed attempt to bribe or manipulate should be refused by the clinician, yet one must still choose words and tone of voice that convey that the refusal is in the best interest of the doctor-patient relationship. The refusal of a small gift may seem petty, but at what point does a “small gift” cease to be small? What if the gift is somehow too intimate? Or what if it is cash? What about those patients in whose country of origin gift-giving is the only means to ensure quality care?

The clinician should consider how the gift might affect his or her ability to care for the patient in a fair and objective manner. Ask yourself: If I accept this gift, will I feel obligated to spend more time and effort on this patient than I would otherwise?

When refusing a gift, express appreciation for the gesture of giving. Possible language could be the following:

“I appreciate your thoughtfulness, but I have a general rule not to accept gifts from patients. The best gift to me is to know that you’re satisfied with the care I’ve provided.”

Or “Wow, this is a beautiful vase, but I’m afraid I can’t accept it. It’s an ethical issue for me – and I don’t want my other patients to feel obligated to give me gifts.”

Or consider accepting a gift on behalf of a team: “This fruit basket is beautiful; our office staff will be so appreciative.”
Or suggest a donation to a charity: "I noticed you included $50 in your Christmas card to me, but really, the sentiments in the card were all I needed. I can't accept the money personally, but would be happy to donate it to ___ charity”

Please click the video-button on the left and watch Dr. Gaufberg commenting on these issues.

The American College of Clinicians (ACP) position paper, the Ethics Manual, states, “A small gift to a clinician as a token of appreciation is not ethically problematic.” They note consideration should be given to the nature of the gift, the potential implications for the patient-­clinician relationship, and the patient’s probable motivation and expectation. Individual institutions differ on their rules regarding accepting gifts from patients, but the most important rule of thumb is to consider how acceptance or refusal of the gift will ultimately affect the clinician-patient relationship. As with all “boundary challenges”, discussion with a mentor or supervisor helps clinicians achieve perspective and resolve issues in a satisfactory manner. Spence suggests that clinicians keep a record of all gifts offered or received, and discuss the issue openly with colleagues in order to promote transparency.(8)

Social invitations from patients

Every professional interaction has a social component and satisfies normal needs for human connection. The decision to socialize with a patient requires that you first clarify the limits and nature of a ‘dual relationship.’

Please click the video-button on the left and watch the "The Dancer” vignette.

The "dancer vignette" stimulates at least the following questions:

1. Is it ever acceptable to accept a patient’s social invitation, or extend one to a patient?
2. What are the pros and cons to socializing with patients outside of the medical setting?
3. What questions might this clinician ask in deciding whether to attend the performance?
4. If the genders of clinician and patient were reversed, would this affect your response to the scenario?
5. What if the clinical setting were different (e.g. ER, Primary Care, Psychiatry)?
6. What if the clinician were providing on-going care to the patient?
7. What should the clinician do and say in this scenario?

Please click the 5 video-buttons in this table and watch the different ways how this could develop:

A decision whether to enter into a social relationship with a patient is complex and dependent on several variables. What are the norms about social interactions based on location (rural vs. urban) and setting (psychiatry vs. primary care vs. specialty fields)?

Will the clinician be able to remain objective and to maintain patient confidentiality? Does the patient wish to initiate a friendship, or a romantic relationship, or does the patient hope for special treatment from the clinician? What are your own feelings toward this patient— a sexual or romantic interest should immediately trigger your “boundary alarm!” How might socializing with a patient affect other patients who may learn of the social interaction? Remember the inherent power differential and how that will inevitably have some effect on any personal relationship with a patient.

Please click the video-button on the left and watch Dr. Gaufberg commenting on these issues.

If you decide to socialize, acknowledge that you have both a personal and a medical relationship, in fact a ‘dual-relationship’. The clinician should initiate a conversation that results in clear definition of the nature and limits of the relationship. For example: can the “friend” now call the clinician at home about medical issues? If there is any interest in an intimate relationship, the professional relationship must be terminated.
Clinician-patient touch

Clinician-initiated touch should be limited to sanctioned physical examination techniques and simple comforting gestures. Explain potentially misconstrued contact in advance, respond graciously to patient-initiated touch, and set clear limits whenever you are concerned about the meaning of a physical gesture.

"The Hug" vignette leads to the following questions:

1. What motivates the patient to give the doctor a hug?
2. What should the clinician do and say in this situation?

Many factors determine how individuals feel about hugs and other forms of touch, as each of us is influenced by cultural, social and family norms. Medical training and role modeling further influence clinicians. Touch may be initiated by either the clinician or the patient, who will differ in their understanding of the meaning of touch and their comfort level with various forms of touch.

Additionaly, clinicians break a normative social taboo during physical exams, touching patients in intimate places. Touch is sanctioned in this particular relationship, but the physical exam always includes close attention to the patient’s privacy and comfort, through use of drapes and chaperones. The clinician must ascertain that patients are aware of the rationale for any clinician-initiated touch. Preface any physical contact that might be misconstrued, such as a pelvic exam in the work-up of abdominal pain and fever in a sexually active woman, with an explanation of the rationale for the exam.

Clinicians have other reasons to touch patients, such as providing comfort, communicating warmth or validation, or signaling dominance. The clinician must only initiate physical contact that is intended to meet a presumed therapeutic need of the patient. It is safer to refrain from demonstrative touch such as a hug, especially if you do not know the patient very well. To convey the same sentiment as a hug, choose
words that express the feeling, or consider a gentle touch on the patient's hand or arm. It is normal to occasionally feel attracted to a patient. If you find yourself sexually attracted to a patient, you must not only avoid any physical demonstrations of affection, but also avoid being overly friendly in your words and manner. If your feelings of attraction continue in an ongoing relationship, discuss this with a colleague or mentor.

Patients may initiate touch with clinicians for a variety of reasons, such as communicating warmth or appreciation, displaying relief, seeking approval, dependence, or a closer relationship with the clinician, or transmitting sexual desire or interest. Consider the intent behind patient-initiated touch. If uncomfortable for any reason, you can set limits in a respectful manner. Possible approaches to limit setting include acknowledgment of the gesture of the hug, and an offer or modeling of a different means of expression. You might use body language to model preferred behavior (an outstretched hand for a handshake in anticipation of a hug). (9)

Other strategies that help to set limits include the following:

- Openly name the issue, and cite personal or cultural differences.
  "You seem to be someone who expresses feelings with hugs. Our nurse manager is the same way. That’s great -- but I’m more of a hearty-handshake type."
  Or, "Wow, you really surprised me with that hug. In Asian culture, we pretty much limit our hugs to immediate family – a handshake or a high-five would work better for me! I’m really happy that you’re relieved that everything’s ok."
- Set a general rule or cite professional standards:
  "I’m glad you’re so pleased with the lab results, and I should let you know that I have a general rule not to hug my patients –in today’s social climate we clinicians are discouraged from hugging."
  Accompany such statements with the offer of a handshake or a warm smile.

---

**Discussion about Boundary Issues**

Elizabeth Gauberg, M.D., MPH and Dennis Novack, M.D., are having a discussion about boundary issues

---

**CONCLUSION**

Mutual caring between clinician and patient only thrives within the mutually understood boundaries of a professional relationship.

Clinician-patient relationships are therapeutic in themselves. Mutual caring between clinician and patient promotes and augments trust, safety, confidence and hope. This caring is an essential aspect of therapeutic and healing relationships, and it can only thrive within the mutually understood boundaries of a professional relationship. Occasionally, unexamined feelings or misinterpreted communications by patient or clinician lead to incursions beyond those boundaries, and such incursions always threaten the relationship. Principles to address boundary issues include operationalizing altruism, seeking to understand the patient's and your own motives and needs, being vigilant about the power differential inherent in clinician-patient relationships, and consulting with colleagues or mentors when a problem arises. If unsure of the most effective response in a moment, it is safer to err or the side of firmer boundaries.
References


Additional References

General

Self –Disclosure

Sexual Attraction toward Patients
Rationale
Allison Ferris MD

Questions for Reflection:

1. Think about a teacher you admired. What did he or she do to enhance your learning?

2. How did this great teacher motivate you or inspire you?

3. As a teacher, what are your strengths, and what do you need to work on?

4. What attitudes do you hold about teaching, and about learners, that enhance your effectiveness, or limit it?

Key Principles:

1. Ultimately, clinical teaching aims to assist your students to become self-directed, lifelong learners.

2. Teaching is a complex process requiring attention to both the patient and the learner(s), including an accurate diagnosis of the patient’s problems and an accurate diagnosis of learners needs.

3. You can maximize your effectiveness by adopting the following practices:
   - improve your knowledge of the principles of education, curriculum development, and teaching techniques
   - reflect on your attitudes
   - practice relevant skills
   - seek, welcome and act on constructive feedback,
   - cultivate self-awareness about your teaching practices.

4. Teaching at the patient’s bedside is an opportunity for effective role modeling, direct observation of learners in action and demonstration of clinical skills.
Small group teaching, such as teaching rounds with hospital teams, requires planning, facilitation skills, and use of discrete types of questions.

**Learning goals:**

At the conclusion of this module, you will be able to:

- describe elements of an effective teaching session
- list your own strengths and weaknesses as a teacher
- lead small groups of learners more effectively
- enhance your effectiveness as a clinic preceptor
- improve your mentoring of junior colleagues

**INTRODUCTION**

Teaching is at the heart of the medical professions.

Much of what we know we have learned from the examples and teachings of our parents, teachers, siblings and friends. When we experience the pleasures of learning, it encourages us to pass along what we have learned to others. Along the way we also learn that teaching is, in many ways, its own reward. Many of us have experienced the gratification of teaching something important to a friend or colleague that makes a difference in their lives. Teaching can be exciting and stimulating when it is going well, connecting us to what we value in our work.

Teaching is core to a doctor’s role. In fact, the origin of the word “doctor” comes from the Latin, “docere,” meaning “to teach.” We teach patients about their diseases and how to care for themselves. If we use effective teaching techniques patient understanding, adherence, and outcomes improve. We teach junior colleagues, who then deliver better patient care.

Indeed, as we progress in medical education, we are expected to teach, and in preparing for teaching sessions, we often learn new material that helps us as much as the learners. It has been estimated that house staff spend 20% of their time teaching. Even these inexperienced teachers impact learners by their role modeling. All clinical teachers must remain cognizant of the impact that their behaviors and attitudes have on learners. We can enhance our effectiveness as teachers and role models by developing certain attitudes, knowledge, skills and self-reflection.

One core goal of clinical teaching focuses on the process of enhancing learners’ clinical reasoning. That’s the process of creating a problem synthesis (or one sentence descriptive title), generating hypotheses that are tested through focused data gathering with continuous reassessment of differential diagnoses, establishing the most likely diagnosis (and identifying any must not miss diagnosis), then creating an evaluation strategy to refute or confirm the diagnosis. Exposing every component of the clinical reasoning process is a goal of clinical teaching, in order to identify gaps, correct errors, and promote better refinement of reasoning.
If one of the end products of all clinical teaching is to enhance learners’ clinical reasoning, still we do much more than that in our teaching. Through our manner with learners and patients we model professionalism, including respect, kindness, attention to learners’ and patients’ worries and suffering, and using our abilities to not only diagnose and cure, but to understand and promote healing. The best teachers inspire, and pass along their wisdom and art to contribute and to leave something behind – to enhance the lives of current and future patients, families, and communities.

HOW ATTITUDES AFFECT TEACHING

Attitudes shape behaviors. Positive attitudes about teaching and about your learners enhance your effectiveness as a teacher.

Attitudes that enhance your teaching include enthusiasm for teaching (1) and patient care, respect for your peers and junior colleagues (2), caring about your learners as people, and concern for their educational needs and for their personal and professional growth. If you believe that your students are basically well-intentioned and trying to do their best, you are more likely to be generous with your praise for their efforts, forgiving of small mistakes and supportive of their stretching their limits. If you believe that your students are lazy and trying to get away with doing as little as possible, don't really care much for what you are teaching, aren't as dedicated as you and your colleagues were, or are not striving for the high standards that are your ideal, you may only see their faults, be stingy with your praise, and generous with your criticism. Positive and negative experiences with teachers help shape our attitudes. For example, some faculty members learned through being "pimped" and humiliated in front of their peers (3), and came to believe that this is an effective way to teach. For most, humiliation inhibits learning.

Moods and affective states affect our attitudes. If you are feeling resentful, angry about your personal or professional situation, unfairly treated by your seniors, not good enough or smart enough, or feeling envious or angry towards certain junior colleagues on your team, these negative emotions will surely inhibit your ability to be an effective teacher. A number of faculty members and house staff are burned out or depressed, causing them to have negative attitudes and to be irritable with others. (4) On the other hand, if you are feeling confident, secure in your knowledge and abilities, and can provide positive energy to your rounds and teaching sessions, these emotions will be infectious and contribute to a positive learning environment.

It can be worthwhile to ponder and discuss these questions: What are your basic attitudes about yourself and towards your peers and junior colleagues? How confident are you in your sense of yourself as someone who can contribute to others and be a role model to junior colleagues? What do you value about being a teacher? How might your emotional state and your attitudes be enhancing or inhibiting your ability to be an effective teacher?

The first step towards improving your effectiveness as a teacher involves self-reflection. Your abilities to teach improve as you grow personally through enhanced self-reflection and self-awareness. It can be helpful to discuss your doubts, fears, concerns and insights with trusted colleagues and friends as a way of promoting your personal growth, as a person and as a teacher. Much has been written in recent years about attending to and improving self-awareness in medical education. Novack, Epstein and their colleagues summarized the issues related to enhancing self-awareness and reflection in medical education and care. (5, 6) Finally, it is worth emphasizing the point about caring for your learners. Peabody (7) famously said that the secret in the care of the patient is in caring for your patient. The same can be said for teaching. If you respect, honor, and care for your learners as individuals, they will know that,
GUIDELINES FOR EFFECTIVE CLINICAL TEACHING

Effective clinical teachers understand and employ diverse educational strategies in order to engage and stimulate the intrinsic motivation of their learners.

Novack and colleagues summarized educational principles relevant to teaching medical interviewing (8). In the following section, we describe 10 guidelines that apply to teaching in clinical medical settings.

1. Define goals and objectives and reach agreement with learners
2. Assess and address learners’ knowledge and motivation
3. Teach knowledge and skills sequentially from simple to complex
4. When you teach skills, define them and present them as discrete behaviors
5. Enhance learning of knowledge and skills through repetition and reinforcement
6. Provide effective feedback
7. Ensure early success
8. Monitor and attend to learners’ emotions
9. Provide opportunities for interaction, questions, and reflection
10. Provide formative and summative evaluations

1. Define goals and objectives and reach agreement with learners

Discussion and development of shared goals and objectives at the beginning of rotations as well as the beginning of individual sessions enhances all learning activities.

The maxim that if you don't know where you're going it's unlikely you will get there, and you surely will not know if you have arrived, applies to clinical teaching activity. Learners and faculty who share expectations prepare better, stimulate and engage with each other's needs and can measure progress. In discussion, both learners and teachers may wish to modify objectives or add new ones, according to their learning needs. Interns and residents will learn more in a rotation if they sit down on the first day and agree upon goals, responsibilities, expectations, and what they hope to learn and teach during the rotation. Even when beginning a session to teach a discrete topic, it is helpful to outline the main goals of the session, seek agreement and with your learners, and give them a chance to add other related goals.
2. Assess and address learners' knowledge and motivation

As a rotation or session begins, assess learners’ knowledge, perspectives and feelings, so that you can address misconceptions and fine tune your teaching strategies.

Address learners’ motivation about a session or rotation to maximize their learning. When learners think they fully understand the topic you are working on, they are unlikely to pay close attention. Some learners may have preconceived notions about your topic area, and close their minds to new learning. Sometimes it is helpful to administer a brief pre-test of knowledge, self-efficacy, and attitudes, to assist learners in becoming better aware of their educational needs.

3. Teach knowledge and skills sequentially from simple to complex

Start with the basics, or review the basics when teaching complex concepts and skills.

Many concepts and skills that comprise medical practice are quite complex. Students learning the complexities of acute renal failure must first understand acid base balance and the ranges of normal electrolytes. Similarly, skills, including interviewing, physical examination and other procedural skills, rely on learning basic skills first. Members of house staff teams from diverse backgrounds may have had different experiences with learning certain basics. You will often need to assess their familiarity with core concepts and review some basics before teaching advanced topics. Begin your teaching from the level of learner understanding.

4. When you teach skills, define them and present them as discrete behaviors

Clearly describe skills, demonstrate them, and articulate performance standards (anchors).
Whether you're teaching simple or complex skills, describe orally and in written handouts the behaviors that comprise them. Demonstrate the skills and articulate performance standards (anchors) that allow learners to assess their progress against those standards. Observe learners as they practice, and teach learners to observe each other and give feedback, using the anchors. Showing brief videos of effective skill performance in a medical context can enhance understanding.

5. Enhance learning of knowledge and skills through repetition and reinforcement

Present alternative descriptions of key principles and show multiple examples of important or complex skills.

“See one, do one, teach one” is seldom the most effective technique for mastery of skills. Sometimes learners must see complex procedures multiple times before attempting them with expert guidance and repetition until mastery. For behaviors or concepts that are especially important or particularly complex, give multiple examples that shed further light on their utility and execution in varied contexts.

6. Provide effective feedback

Giving feedback shows learners that you are fully engaged, and feedback speeds learning of knowledge and skills.

When you give feedback to learners and demonstrate that you can both praise success and help them with deficiencies, you show that you value your teaching role. You build trust and relationship, show your willingness to fully engage, and show that you value their success. Your engagement with learners through your feedback thus individualizes and speeds the learning process. Learn feedback principles and be certain to capitalize on the many opportunities presented to you for using feedback as a teaching tool. (9) In addition to formal feedback sessions, feedback can be used within teaching sessions to facilitate learning for the individual and the group. Module 40 presents principles and guidelines and illustrates the process in varied contexts.

7. Ensure early success

Ensure that learners can demonstrate knowledge or skill acquisition.

When learners experience success in learning, that success enhances their confidence and motivation to continue learning. Establish goals and objectives that most learners will be able to achieve and demonstrate in that session or within a short time. Organize learning activities that provide opportunities to observe and comment on learner successes, perhaps through quizzes, evoking discussion with good questions, skills practice in role play or other simulation. Whether you are teaching new knowledge or new skills, your honest praise to students for their successful learning increases their self-confidence and enjoyment of learning, as well as their regard for you as a teacher.
8. Monitor and attend to learners' emotions

When you respond with empathy to learner expression of reluctance, stress and distress, your sessions can be more effective.

The stresses of medical school and residency training can lead to anxiety and demoralization. These and other negative attitudes and emotions, such as feeling inadequate, guilty or lonely, inhibit learning. Monitor the emotional "temperature" of learners. Sometimes group members will seem somber, or stressed, or be reluctant to answer questions. Some learners, especially in the middle of an internship, may be depressed or burned out. Sometimes you as a teacher may be asking too much of your learners or you may have inadvertently said something that left them confused or upset.

You create an atmosphere that maximizes learning possibilities when learners know you care and that you understand their feelings. If you ignore, put down or make light of learner distress, you add another obstacle to effective learning. If, on the other hand, you inquire about what people are feeling and show your concern and willingness to try to address some of the issues, you can "clear the air," motivating and preparing your learners. Of course you cannot take responsibility for resolving outside situations, but simply acknowledging their significance reassures learners, freeing them up to participate. Sometimes you learn something as simple as that group members are in the middle of major tests, or boards. You further enhance engagement and motivation when you provide encouragement and emotional support in a non-judgmental and empathic fashion.

9. Encourage interaction, questions, and reflection

Demonstrating that you value comments, questions and interactions from each learner and among all team members stimulates learning and assimilation of new material.

You set the tone for exciting and stimulating learning on ward rounds or in small group sessions when you invite and value interactions among all group members. Improve group interaction by encouraging questions and comments. Ensure that learners know that all questions are good questions. Acknowledge and praise comments and questions, and use them as springboards for your own questions and comments, as you put them in perspective for the team. Further stimulate discussion by asking provocative questions and encouraging learners to take intellectual risks in proposing diagnostic hypotheses or solutions to problems.

Reflection, that is, the consideration of the larger context, the meaning, and the implications of an experience or an action, allows the assimilation and reordering of concepts, skills, knowledge, and values into pre-existing structures. Ask learners to take time to reflect on what they are learning, both in real time and after the session. Encourage individuals to return to the next session and share the insights they attain. Active reflection promotes the professional growth of individuals. (9)

10. Provide formative and summative evaluations
Each skillfully conducted evaluative conversation (written or oral) that you conduct with learners motivates and assists them in setting further learning goals.

Formative evaluations help learners shape their learning. Summative evaluations communicate students' grades and reveal the knowledge or skills on which they need to continue working. To maximize the benefit of evaluations, schedule them in advance, and assure that your learners share the expectations, goals and objectives of the evaluations. When provided in a constructive and personal but non-judgmental manner, evaluations motivate learners to continue in their pursuit of knowledge and skills. Learners may not share your expectations or goals for a course or rotation, or may become side-tracked by other concerns, so do not omit mid-block or other formative evaluations that can redirect learners' efforts.

---

**STAGES OF COMPETENCY DEVELOPMENT:**
**TEACHING LEARNERS WITH DIFFERING EDUCATIONAL LEVELS**

Clinical teaching often involves learners at differing educational levels. Identify learners' levels and adjust your instructional strategies to meet their needs. (11, 12) Each level requires knowledge, structured experiences, emotional buy-in, reflection on action, role models, and learner-centered instruction for most effective progress toward the next levels.

In this section, we address the differing needs of Novice Learners, Advanced Beginners, and Competent Residents, and discuss appropriate teaching strategies.

- **Novice Learners**
  For novice learners, highlight key pertinent data from their exams that help distinguish among diagnoses and encourage more intensive study of one or two competing hypotheses about diagnostic or treatment options.

- **Advanced Learners**
  For advanced students and interns, require them to formulate differential diagnoses, help them to set priorities, and reinforce the meaning of context to the clinical problems.

- **Competent Learners**
  For increasingly competent residents, balance supervision and autonomy, helping them become aware of the emotional and clinical care consequences both of never asking for help or lacking the confidence to trust their own thinking and decisions.

---

**Novice Learners**

For novice learners, highlight key pertinent data from their exams that help distinguish among diagnoses and encourage more intensive study of one or two
competing hypotheses about diagnostic or treatment options.

The novice learner on a clinical team has little clinical experience, typically at a second or early third year medical student level. The novice is unable to filter or prioritize data so that synthesis is difficult. Everything seems equally important. With little experience to draw upon, the student performs best when provided rules, such as “when you encounter this, do that,” or “when an adult patient complains of chest pain, always identify cardiovascular risk factors and assess for cardiac causes.”

On their first clinical rotations, novice students typically perform H&Ps using a set of rules or templates. Regardless of the Chief Complaint, they methodically go through each item on the generic template. They have no capacity to focus the information gathering on the basis of a likely differential diagnosis and do not yet comprehend the big picture. When preparing a written H&P, pertinent positives and negatives remain scattered throughout the ROS rather than being discussed in the HPI. Each sign and symptom seems equally relevant. These students still have limited abilities to synthesize the myriad pieces of information into a unified summary. Using learned rules, they link the clinical data to their knowledge of the pathophysiology of disease.

The teacher can employ specific strategies for novice level learners:

- Provide rules.
- Point out meaningful diagnostic information in H/P.
- Eliminate irrelevant information.
- Highlight discriminating features with relative importance to diagnosis.
- Encourage reading of two or more diagnostic hypotheses to compare and contrast.

---

**Advanced Learners**

For advanced students and interns, require them to formulate differential diagnoses, help them to set priorities, and reinforce the meaning of context to the clinical problems.

The advanced beginner is typified by third and fourth year students through early internship who have experience with many clinical encounters. Advanced beginners use their experience to sort through rules and data to decide what is relevant. They begin to use pattern recognition to solve problems, seeing the big picture and how specific information relates to it. They begin to create their own personalized rules and “maxims” from meaningful prior experiences.

At the beginning of the intern year, when advanced beginners are taking H&Ps, they begin to generate a differential diagnosis that drives data gathering in a more focused direction. Because they are capable of filtering information and focusing on the relevant, they are able to formulate a unified summary of the case. When writing notes, they can abstract the pertinent positives and negatives from the ROS and appropriately incorporate them into the HPI.

Recognizing the advanced beginner on the team, the teacher can employ specific strategies individualized for this competency level:

- Support in setting priorities.
- Help identifying meaningful patterns in various situations.
- Work from the common to the uncommon.
- Reframe data, such as the Chief Complaint, into problem representations.
- Require the formulation of differential diagnosis.
- Be attentive to meaningful or situational aspects of the clinical presentations, to reinforce importance of context.

## Competent Learners

For increasingly competent residents, balance supervision and autonomy, helping them become aware of the emotional and clinical care consequences both of never asking for help or lacking the confidence to trust their own thinking and decisions.

Competent residents, usually approaching the end of residency, possess a wealth of clinical experience upon which to compare and contrast patient presentations. This provides competent clinicians with a perspective to determine important or ignored elements. They are able to see the big picture, using clinical reasoning tips from analytic to pattern recognition for solving common problems, but complex or uncommon problems require reliance on analytic reasoning. Because supervising residents must decide what plan to choose and when to choose it without being sure, every situation requires coping with uncertainty, which is both frightening and exhausting. It becomes an emotional roller coaster consisting of the pain of mistakes and elation of successes. Self-awareness allows managed emotional involvement, which advances development. Without self-awareness, this roller coaster may produce resistance to risk or responsibility, which leads to stagnation of development.

Competent residents build on many clinical experiences as they near the end of residency, and recognize common illness patterns. They easily see the big picture. Because of their enlarged responsibilities, they see more consequences of their clinical decisions, which results in an emotional buy-in to learning. When they encounter new or unfamiliar problems, they methodically reason through each step of the case, sometimes successfully and sometimes getting stuck. They feel responsible for their decision-making process and are consciously aware of their own roles in contributing to the clinical outcomes.

Recognizing the competent learner on the team, the teacher can employ specific strategies individualized for this competency level:

- Balance supervision with autonomy.
- Hold competent learners accountable for decisions.
- Telling what to do prevents emotional buy-in.
- Expose the competent resident to the breadth and depth of problems to construct illness scripts (patterns).
- Reassure these residents that it ok to not know and to ask for help. This is important for all levels of learners, but perhaps more so for the competent resident who may feel that at this level they are expected to be masterful in all instances.

## ENGAGING LEARNERS AND STIMULATING LEARNING IN CLINICAL TEACHING SETTINGS

In the following sections we discuss concepts and skills that promote active learning, in groups and with individual learners.
The topics we address in this section are the following:

- **Role Modeling**
  At each level of training, you will be a role model for junior colleagues.

- **Facilitation skills for small groups**
  Medical students, resident clinicians, clinical faculty and others will lead small groups of learners.

- **Questioning skills**
  Asking questions helps you understand learners’ level of understanding and their learning needs.

- **Video Example**
  At Hahnemann University Hospital in Philadelphia, Dr. Joseph Boselli is one of the most appreciated teachers. We present Dr. Boselli introducing himself at his first attending rounds or a rotation, and intern comments afterwards on why his teaching is effective.

---

**Role Modeling**

At each level of training, you will be a role model for junior colleagues. Maximize your effectiveness as a role model by strengthening positive personal qualities, clinical proficiency and teaching expertise.

Young clinicians look to their senior colleagues for inspiration and guidance in all aspects of the practice of medicine. Role models shape those values, attitudes and skills that characterize clinician “professionalism,” as well as students’ career choices. (13) In today’s hectic healthcare environments, excellent role models are harder to find, and many harried clinicians demonstrate distinctly unprofessional values and behaviors. Recent studies of role modeling and the processes of learning through role modeling have identified qualities of excellent role models and key aspects of learning from them. (14)

In one important study, house staff at four hospitals identified 141 clinicians as excellent role models. In contrast to 200 other attendings, the excellent role models were more likely to have attended teaching workshops, to stress the importance of the doctor–patient relationship in their teaching, to teach about the psychosocial aspects of medicine, and to provide in-depth feedback to house staff. They were more likely to say they enjoy clinical teaching, to rate themselves more highly as a role model and to share professional and personal experiences with learners. (13)

According to another recent study (15), some qualities of role models that learners value highly include personal attributes such as compassion, a sense of humor, and integrity, clinical proficiency in diagnosis, effective interaction with patients and families, and skillful teaching such as the ability to explain complex subjects, stimulate thinking and interact in a non-threatening manner. The authors of this study suggest several strategies you might undertake to improve the “role model” aspect of your teaching. These strategies include the following:

- Be aware that you are a role model with learners at every level.
- Show that you value this role.
- Demonstrate clinical competence.
- Be explicit about what you are modeling, whenever possible.
- Help learners reflect on your modeling and what they learn from it.
• Protect time for teaching.
• Implement a learner-centered approach to teaching.
• Encourage dialogue among colleagues.
• Engage in pertinent faculty development.
• Work to improve the institutional culture.

---

**Facilitation skills for small groups**

Medical students, resident clinicians, clinical faculty and others will lead small groups of learners in rounds, case conferences, didactic informational sessions and other settings. We incorporate attitudes, educational principles, and skills into a summary of keys to effective small group teaching.

The areas we include for more intensive review and study are the following:

- **Planning learning sessions**
  For your assigned and scheduled teaching sessions, develop goals, divide the time into segments and follow your schedule.

- **Skills for opening and conducting a session**
  Always let participants know that you care about their learning.

- **Skills for monitoring the pace and for closing a session**
  Be aware of elapsed time, devote time to a summary of the session and involve participants in debriefing your leadership and the session’s effectiveness.

---

**Planning learning sessions**

For your assigned and scheduled teaching sessions, develop goals, divide the time into segments and follow your schedule, use more than one teaching strategy, and have a written or digital handout.

Planning improves the quality of learning sessions. Decide on your goals and objectives and write them down. Determine what materials and teaching methods you will use to achieve these goals and objectives. Provide a handout that summarizes essential points and might also serve as an outline for the session. Decide approximately how much time you will allot to each learning objective, and each segment of the session. Develop teaching strategies for each segment and vary teaching methods, not only to keep the session consistently interesting, but also to address varying learning styles of participants. For example, in planning a session around a patient with a particular problem, you might briefly introduce the topic, ask participants for their experiences in dealing with this problem and discuss those, highlight the important information to elicit from patients, do a brief patient interview and exam, discuss these findings and their implications, and then summarize essential learning points, referring to a brief handout or article. When teaching about healthcare relationships and communication skills such as discussion about advance directives, including time for succinct, focused role-plays can be illustrative and engaging.

---

**Skills for opening and conducting a session**
Always let participants know that you care about their learning. Use words and non-verbal communication to show that you welcome questions and comments. Acknowledge contributions and involve everyone.

First impressions set the tone. When beginning a new group, take a few minutes to introduce yourself and invite each of the participants to do the same. You might ask them about their backgrounds and interests, to say something that nobody knows about them, what they are hoping for in this group, etc. Getting to know participants in a personal way helps set a positive learning climate. Communicate to participants that you care about them and their professional development, and that a key goal for your own work is to foster a stimulating, fun, and safe environment, with their help.

Keep your session learner-centered. In addition to soliciting learners' feedback on whether the session was learner centered, another gauge is this: if you leave thinking you really showed them how much you know, you may have missed responding to what they really needed to learn.

An additional goal for group leaders is to help participants to share opinions, take intellectual risks and work together. Welcome questions, and invite other group members to respond to them before you do so. Involve the quiet members of the group, (“John, I would be interested in hearing your opinion,”) and solicit contrary or minority opinions (“Shireen, from what you’ve said, I expect you might have another opinion on this- if so, would you share it with us?”) Acknowledge each learner’s contribution. Become a patient listener, ask simple questions that help learners refine their thinking, and notice what concerns they are not saying that may be relevant. Share your own insights and experiences only when they will advance the dialogue, never to show that you know the “right answer”.

When working with a group of multi-level learners, such as a ward team, you might begin with a basic question and gradually move to advanced questions directed at the senior members. In that way, everyone can participate and know they have contributed to group learning. Observe and comment occasionally on non-verbal expressions of confusion, excitement or disinterest. When someone appears bored or uninterested, you might ask the learner his or her perspective on the issue. Your intervention can provoke useful adjustments to pace, tone, involvement or topic.

Skills for monitoring the pace and for closing a session

Be aware of elapsed time, devote time to a summary of the session and involve participants in debriefing your leadership and the session’s effectiveness, and close at the designated time.

Keep one eye on the clock, because interesting discussions that go over the time that you’ve allotted can limit coverage of additional key topics. Of course, flexibility trumps rigidity in dynamic learning sessions, but you need to take charge, perhaps saying, "This is a fascinating discussion, and we need to move on. Jason, would you look up a review article on this topic and report back tomorrow?"

Remember that every person on the team is as busy and committed as you are, and that closing at the designated time shows that you respect the needs of the team members.
As the session approaches closing time, take steps to solidify learning, reach closure, and plan for the next session. Ask participants to summarize the key lessons, and as you listen, paraphrase individual contributions. At times, you might ask each group member to say one thing they learned, or what they might apply in their clinical work in the next week. Identify learning issues for the next session, and if you haven’t done so already, ask a volunteer to look up the answers to questions or to make a brief presentation at the next session. Seek feedback about the session’s learner-centeredness and utility, and inquire about how the group and your leadership could be more effective.

**Questioning skills**

Asking questions helps you understand learners’ level of understanding and their learning needs. Skillful questions stimulate learners’ thinking and motivation to learn more.

Group participants learn best when they are actively engaged in learning. Your questioning skills can be powerful in stimulating learning. When you engage learners in discussion through use of questions that expand their thinking and stimulate problem-solving and critical thinking, you promote active learning. Many obstacles can reduce the effectiveness of otherwise effective questioning strategies.

The following list shows some common barriers to discussion:

- Requiring a quick response to questions. Allow time for learners to think.
- Framing the question at a level of complexity beyond learners’ expected level of knowledge. Calibrate questions to fit your learners’ needs.
- Conveying lack of confidence that responses will adequately address the question. Show learners that you respect their competence. Praise successes, however small.
- Allowing only strong learners to respond to inquiries. Call on other learners when you have someone who is too quick.
- Ignoring the student’s fear of being wrong. Remind learners that “wrong, or off track” does not equate to “poor effort, or bad student”, and that learning from mistakes or poor thinking facilitates better understanding.

The types of questions we include for more intensive review and study are the following:

- **Open-ended Questioning**
  Open-ended questions facilitate discussion and help you assess learners’ cognitive strategies and ability to generate and test hypotheses.

- **“Follow-up” questions**
  Use increasingly closed-ended questions to involve learners who may be less facile with higher cognitive strategies.

- **“Directed” questions**
  Directed questions help you guide learners’ thinking and stimulate problem-solving.

Excellent sources for these kinds of questions are "The Clinician as Teacher" by N. Whitman and T.L. Schwenk, and "Residents as Teachers: A Guide to Educational Practice, by T.L. Schwenk and N. Whitman(19, 20)
Open-Ended Questioning

Open-ended questions facilitate discussion, rather than seeking “right” answers, and help you assess learners’ cognitive strategies and ability to generate and test hypotheses.

Open-ended questions possess characteristics that promote active learning. For example, they seldom have “correct” answers, they suggest that people may have differing answers and they require that responders consider more than one factor in developing answers. Additionally, the questioners may have some ideas but is asking for responses they might not have considered. The questioners wish for respondents to “think out loud” rather than parrot the “right” answer.

Asking open questions can help you avoid the normal tendency to show your knowledge, and help learners better grasp complex ideas or concepts. Putting out your own “expert” interpretation too early can suppress thinking and discussion by others. When someone answers, listen attentively and ask others for their input. A good continuer, if discussion seems slow is to simply reflect back whatever a respondent says, adding something like, “Do I understand you correctly?” or, “Is that what others understood?”

Examples of open-ended questions are the following:

- What is the significance or relevance of a particular fact or observation?
- Why do you think so?
- Who else agrees?
- I’m always interested in hearing from those who might disagree with this notion.
- Is there someone with another take on this?
- What if the circumstances change? For example what if the patient were...
- What do you do next?
- Here is my idea, but I expect there are other ways to look at “x”. What are your thoughts?

Clinical Scenario #1

On rounds, your team sees a patient with HIV admitted for cough and shortness of breath. She has never been on HAART, her last CD4 count was 150, and she takes no medications at home.

**Teacher:** “What is the significance of the CD4 count, and why?”

**Learner:** “A CD4 count less than 200 puts the patient at risk for opportunistic infections such as Pneumocystis pneumonia.”

**Teacher:** “What if the CD4 count is 250—how does that change your thoughts?”

**Learner:** “PCP would be unlikely if the CD4 count were that high. Then you would consider the typical organisms that cause CAP—Strep pneumo, H.flu, M.catarrhalis, L.maltophilia. Also, regardless of the CD4 count, I would consider TB in the differential for this patient.”

**Teacher:** “What do you do next to diagnose this patient’s problem?”

**Learner:** “I would order a chest x-ray, get a sputum gram stain and culture, sputum for AFB, check her pulse oximetry, and check both her CBC for white cell count and order a CD4 count.”
“Follow-up” questions

Use increasingly closed-ended questions to involve learners who may be less facile with higher cognitive strategies, and to help assess the knowledge base of learners.

It may be helpful to build on your questions: start with simple concepts, then ask for further details, gradually leading learners to more complex thinking. This kind of exercise helps learners to expand their thinking.

- Reflecting back on what you just said, could you clarify...
- Tell me more about...
- How do you account for...
- Help me to understand...

Clinical Scenario #2

Your team later sees an elderly male admitted for dyspnea. He is found to have pulmonary congestion on chest x-ray and has rales on his pulmonary exam.

Learner: “So, based on the shortness of breath, rales, and pulmonary vascular congestion on x-ray, we are treating this gentleman for CHF exacerbation with diuretics.”

Teacher: “Tell me more about this CHF diagnosis.”

Learner: “Well, the patient has a history of hypertension and coronary artery disease with several MI's in the past. He likely has a reduced systolic function that led to progressive left heart failure and pulmonary congestion. We should check a 2D Echo to determine his ejection fraction.”

Teacher: “How do you account for this sudden onset of symptoms when he previously had been well?”

Learner: “Well, it could be that he has suffered another MI, perhaps silent, that worsened his systolic function further. If he had a murmur on exam, I would consider worsened valve disease such as mitral regurg that caused this sudden decline. Most likely, though, it has to do with the fact that he admits to not always taking his medications. This makes him more at risk for MI as well as uncontrolled hypertension that may have resulted in this scenario.”

Teacher: “This patient’s medication list—metoprolol, lisinopril, aspirin, simvastatin—help me to understand the rationale behind using these medications.”

Learner: “The statin is for cholesterol lowering, the aspirin is an antiplatelet that helps prevent further MIs, the beta-blocker helps keep heart rate and blood pressure down, and the ACE-inhibitor is for both blood pressure control as well as prevention of cardiac remodeling, a process that occurs after MI and ultimately results in worsened cardiac function.”

“Directed” questions

Directed questions help you guide learners’ thinking and stimulate problem-solving. They model how teachers think critically about problems.
Using directed questions helps learners explore the depths of the situation at hand and understand it more fully. They also begin to imagine the complexity and variety of situations they will likely be called upon to manage that differ slightly from the present one. Examples of directed questions follow:

- Which hypotheses help explain...?
- What data would you need to...?
- How would your hypotheses be ranked if the patient were a .....instead of...?
- If a vital laboratory test was unavailable, what would you do instead?
- What important questions about this patient’s disease remain unanswered?

**Clinical Scenario #3**

The team’s next patient is a 67-year-old man with a long history of smoking and alcohol abuse who was admitted with dysphagia.

**Teacher:** “So this gentleman has a six-month history of progressive dysphagia. What hypotheses help explain his dysphagia?”

**Learner:** “Well, top on the list is going to be esophageal cancer given his age, his history of both heavy smoking and drinking, and his progressive symptoms. An unknown is whether it would be adenocarcinoma or squamous cell carcinoma. Obviously, he is also at risk for other malignancies, lung especially, but he gives no history of pulmonary symptoms. Other possibilities are neurologic such as myasthenia gravis.”

**Teacher:** “What do you do next to help diagnosis his problem?”

**Learner:** “He needs an upper endoscopy.”

**Teacher:** “How would your differential change if this patient had never smoked or drank?”

**Learner:** “Well, the malignancies would be lower on the list, I guess. Myasthenia, especially bulbar myasthenia would go higher. I would also add other possibilities such as esophageal webs or rings. I guess I would also wonder about conditions like esophagitis, possibly from reflux or infectious.”

**Teacher:** “What if our gastroenterology colleagues were all out of town and no one was available to do an endoscopy. Is there a test you could do instead?”

**Learner:** “Well, you could do a barium swallow to look for masses.”

**Teacher:** “Even with endoscopy, what questions may remain unanswered for this patient’s diagnosis and prognosis?”

**Learner:** “Well, obviously, we’d need to wait for the pathology report to come back on any samples that were taken during endoscopy. Also, if it is cancer, we’d need to determine staging with CT Scanning of his chest, abdomen, and pelvis.”

*Please click the video-button on the left and*
watch an attending clinician teaching a student after seeing a patient together. Which questioning skills did he use? How might he have used different kinds of questioning skills to be more effective in his teaching?

Video is loading...

Dr. Joseph Boselli and his Interns

At Hahnemann University Hospital in Philadelphia, Dr. Joseph Boselli is one of the most appreciated teachers.

In this video, Dr. Boselli introduces himself at his first attending rounds of a rotation, and interns comment afterwards on why his teaching is effective.

TAKING THE TEAM TO THE BEDSIDE

The complex dynamics of an encounter with a patient along with multiple levels of learners, each with individualized needs, is a challenge requiring attentiveness to respectfulness of both the patient and all learners. Bedside teaching necessitates careful attention to the patient’s comfort and dignity.

Teaching at the patient’s bedside is a powerful opportunity to role model for learners. They can be inspired by your ability to maintain a delicate balance between showing kindness, respect and caring for the patient and attending to team members’ learning needs. They can observe your demeanor and skills as you examine the patient and conduct parallel conversations with patient, family and team members. Further, you observe firsthand the learners’ interactions with the patient and the patient’s family. Physical examination and communication skills can be directly demonstrated, and the key learning points can be based upon data that all team members directly observe and share. (16-18)

Attend to structural elements of a bedside teaching session to maximize the learning benefit. Obtain permission from the patient in advance of the team’s arrival. Engage all team members in establishing both learning goals and a role for each team member to play. When you approach the bedside, introduce each team member and the purpose of your rounds. Attend to the patient’s comfort and to any communication barriers such as pain, privacy, or need to use the bathroom. Attend to all the learners and give them chances to ask questions or appreciate a physical finding, with the patient’s permission. Share some aspects of the “teacher” role with senior team members, both to demonstrate teamwork and to advance their skills. Avoid jargon, and engage the patient beyond the history and physical, perhaps by asking what she thinks about her doctors’ thoughts or what additional ideas she might have.

Monitor the patient’s physical and emotional state, and cut short the session if the
patient tires. If someone asks an uncomfortable or inappropriate question for that patient, take the opportunity to assure the patient that she is not required to discuss such an issue in front of the group, and remind her about your commitment to confidentiality. In front of the patient, as you conclude the visit, arrange for a team member to return later to clarify any questions or misunderstandings. Finally, solicit feedback on your teaching and role modeling so as to improve your own skills and jointly examine in more depth the impact of selected aspects of the encounter.

Summary of steps to enhance bedside teaching:

- Obtain permission from the patient
- Establish learning goals for the visit and roles for each team member
- Introduce all members of the team
- Attend to patient comfort and understanding
- Encourage interaction and examination of the patient under your observation
- Solicit and provide feedback

FACULTY DEVELOPMENT

No two sessions are alike. You teach beginners or more advanced learners, and mixed groups. Moods change, crises happen, new information becomes available. Teachers who value their work can continually improve.

The material in this DocCom module is necessarily a summary, and brief. Many easily accessed resources can assist the faculty member who wishes to steadily improve. We recommend the following:

In two excellent articles, Azer, Pinsky and their colleagues summarize the qualities of effective teachers and how they use certain strategies to maximize learning. (21, 22)

Kelley Skeff and his colleagues incorporate many of the concepts we discuss in the Stanford Faculty Development Program (http://sfdc.stanford.edu/). They suggest that teachers enrich their capabilities in key instructional categories. Studies show that Dr. Skeff’s program improves faculty teaching skills and educational outcomes. (23)

The instructional categories are as follows:

- Learning climate
- Control of session
- Communication of goals
- Promotion of understanding and retention
- Evaluation
- Feedback
- Promotion of self-directed learning.

Finally, the American Academy on Healthcare Communication (AACH) offers many national, regional and institutional faculty development courses that are high quality, helping many faculty to achieve their potential as teachers. (http://www.aachonline.org/)

SELF AWARENESS
The stresses of clinical teaching may evoke inadvertent hurtful interactions with learners and other staff - even to the point of abusing them. Develop awareness of your “hot buttons” and choose to attempt to respond with empathy. Discussions with trusted colleagues and/or counseling may be very helpful.

Celebrate teaching skills that you carry out well, and give yourself credit. You will grow as an educator if you invite, accept and respond to constructive feedback, learn from your mistakes, and reflect on what goes well and what you might change. Do not let “excellent” be the enemy of the good. Modules 2 and 4 address mindfulness, self-reflection and self care, and certain review articles are also helpful. (5, 6)

Clinical education that involves sick and often dying patients, families and other team members is by its nature stressful for learners and teachers. Sometimes you may realize that you left your learners hurt or bewildered, or receive feedback to that effect. Medical students who wish to “know everything” and “care for everyone” are easily hurt. Furthermore, outright abuse of students occurs, (25, 26) and sometimes we are the inadvertent abusers. Under pressure, for example on a busy ward service, we may be short with some learners, pimp others in a harsh and judgmental way, or deride learners’ “wrong” answers. This may have happened to you as a learner, and maybe you learned a lot from being humiliated, or felt it made you “stronger” in some way. You may think some “unmotivated” or “irresponsible” learners deserve such treatment. However, if you find yourself being hard on your learners, pause and take a closer look. Are unrelated problems diminishing your effectiveness with the learner? Sometimes it is in the relationship with you and the learner. Does the learner remind you of someone with whom you have had problems? Which of your “hot buttons” does the learner’s conduct (or lack of it) push, provoking your defensiveness or counterattack?

At the very least, take the time to engage a shamed, humiliated, reactive, haughty or “bored” learner in a conversation that might not only clear the air but also enrich the educational experience for both of you. Take a close and frank look at your situation, and check your emotional temperature. Are you stressed, burning out, depressed or angry? Are you short with nurses or other staff members? Are your intimate relationships in trouble? If so, make time to speak with someone you trust and consider seeking counseling from a mental health professional. Few people engaged in clinical teaching escape the need to examine and “rewrite” an emotional story or script at some time or other so that we improve our well-being, balance and teaching interactions.

CONCLUSION

Clinical teaching presents unique challenges to the educator. Often, both patient and learner require accurate diagnosis and intervention appropriate to the unique needs of each. The goals of clinical teaching focus on exposing the clinical reasoning process in order to assess the learner and improve their skills and knowledge, while insuring quality patient care. Effective teachers continuously improve their knowledge of the principles of education, curriculum development, and teaching techniques, reflect on their attitudes, practice relevant teaching skills, seek, welcome and act on constructive feedback, and cultivate self-awareness about your teaching practices. Clinical teaching at the patient’s bedside is an opportunity for effective role modeling, direct observation of learners in action and demonstration of clinical skills. Bedside teaching in small groups requires planning, facilitation skills, and use of discrete types of questions. Done well, clinical teaching fosters self-reflection and provides necessary feedback to promote self-directed learning which learners may employ for a lifetime of learning.
BEHAVIOR CHECKLIST

1. Define and agree upon final and intermediate goals and objectives
2. Assess and address learners' knowledge and motivation
3. Teach knowledge and skills sequentially from simple to complex
4. If you are teaching skills, define them and present them as discrete behaviors
5. Repeat and reinforce key knowledge and skills
6. Provide effective feedback
7. Ensure early success
8. Monitor and attend to learners' emotions. Offer encouragement and emotional support.
9. Provide multiple opportunities for interaction, questions, and reflection
10. Facilitate small group teaching by appropriate use of open-ended, follow-up and directed questions.
11. Monitor and adjust the pace of your teaching so that all key topics are covered
12. Provide formative and summative evaluations
13. Identify the developmental level of each learner and adjust to appropriate teaching methods
14. Remain mindful of the impact your behavior and attitudes have on learners.

References


27. Special Resource/Reference for this module: *Print-out Guidelines for Residents*