PATIENT CENTERED CONSULTATION.

COMMUNICATION – MAJOR TOOL IN FAMILY DOCTOR'S ACTIVITY.

Family Medicine Departament

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Subjects of discussion

- Person Centredness – abilities and competences
- Consultation in Family Medicine
  - *Biomedical approach*
  - *Diagnosis oriented approach*
  - *Holistic model*
  - *Folk Model*
  - *Comprehensive approach*
  - *Approach based on patient's needs*
- Calgary-Cambridge Guide

Subjects of discussion

- Communication in Family Medicine
- What does patient want?
- Verbal and Nonverbal Communication
- Communication skills important for consultation
- Factors influencing communication

What does the patient want?

3 “A”

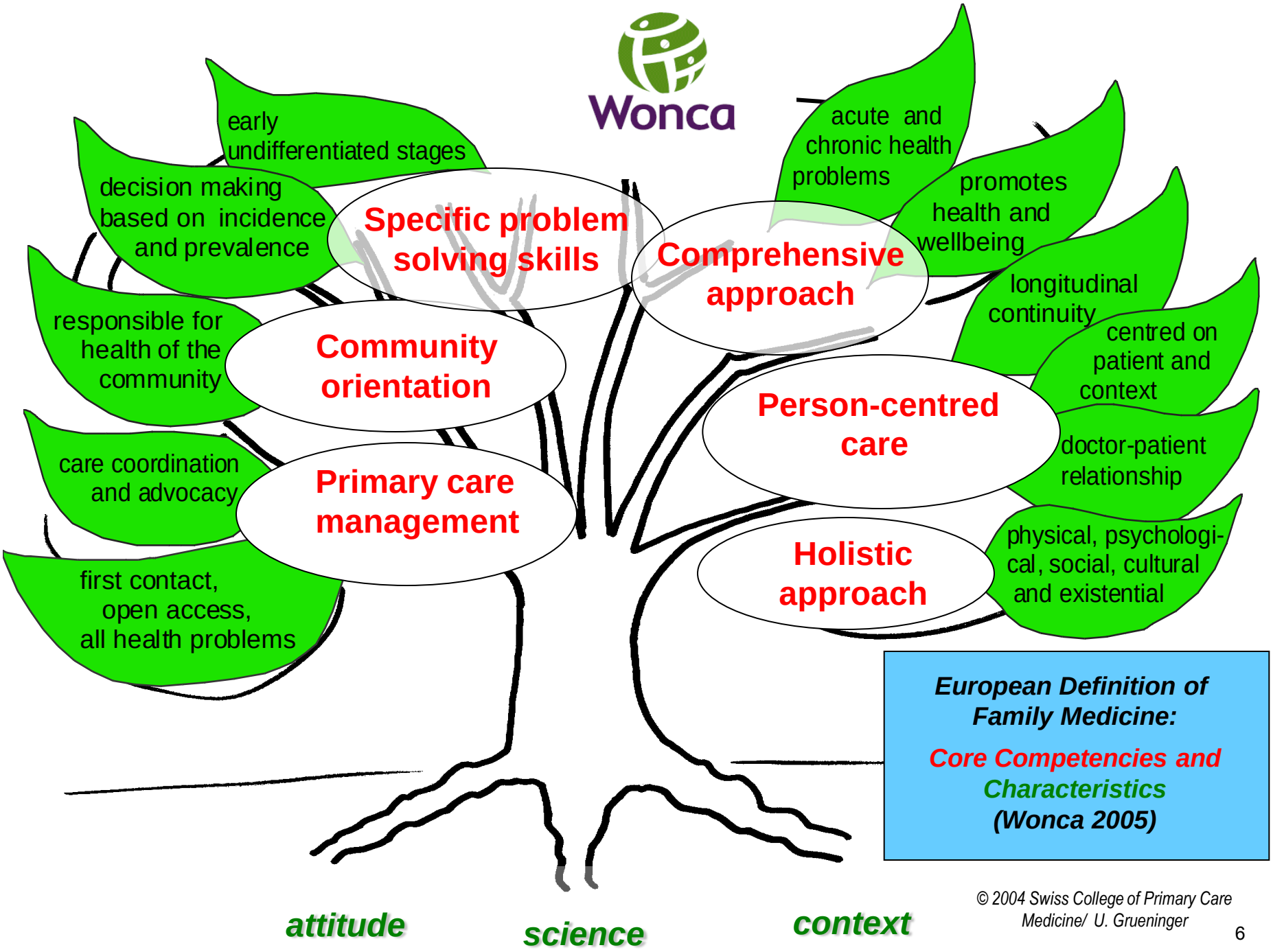
- Accessibility
- Affability (from French - cordiality, kindness)
- Ability

Joseph E. Scherger. MD. Orange, California

The Journal of Family Practice, February 2001
vol. 50. NO 2, p.137

What does the patient want?

- To be listened
- Not to be rushed
- To be informed
- Confidentiality
- Understanding
- Sincerity
- To participate in decision making



European Definition of Family Medicine:

Core Competencies and Characteristics

(Wonca 2005)

Person-centred Care Includes the ability:

- to adopt a person-centered approach in dealing with patients and problems in the context of the patient's circumstances;
- to develop and apply the general practice consultation to bring about an effective doctor-patient relationship, with respect for the patient's autonomy;

www. euract.org

Person-centred Care Includes the ability:

- to communicate, set priorities and act in partnership;
- to provide longitudinal continuity of care as determined by the needs of the patient, referring to continuing and coordinated care management

www. euract.org

Person Centredness means to develop competence on:

A Person centred approach

B Person centred consultation

C Partnership relation

D Longitudinal care

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What is the Person-Centred Approach?

A Person centred approach
B Person centred consultation
C Partnership relation
D Longitudinal care

- The person-centered approach is based on the theory and philosophy of Dr. Carl Rogers (1902 – 1987).
- It is a non-directive approach to being with another; that believes in the others potential and ability to make the right choices for him or her self, regardless of the therapist's (physician's) own values, beliefs and ideas.

http://www.bapca.org.uk/

A Person centred approach
B Person centred consultation
C Partnership relation
D Longitudinal care

- The person-centered approach maintains that three core conditions provide a climate conducive to growth and therapeutic change.

The core conditions are:

- Unconditional positive regard
- Empathic understanding
- Congruence

http://counsellingresource.com/lib/therapy/types/person-centred/

The first — **unconditional positive regard**

A Person centred approach
B Person centred consultation
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means that the counselor accepts the client unconditionally and non-judgementaly. The client is free to explore all thoughts and feelings, positive or negative, without danger of rejection or condemnation. Crucially, the client is free to explore and to express without having to do anything in particular or meet any particular standards of behavior to ‘earn’ positive regard from the counselor.

The second — **empathic understanding** —

A Person centred approach
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means that the counsellor accurately understands the client's thoughts, feelings, and meanings from the client's own perspective. When the counsellor perceives what the world is like from the client's point of view, it demonstrates not only that that view has value, but also that the client is being accepted.

The third — **congruence** —

A Person centred approach
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means that the counselor is authentic and genuine. The counselor does not present an aloof professional facade, but is present and transparent to the client. There is no air of authority or hidden knowledge, and the client does not have to speculate about what the counsellor is ‘really like’.

Consultation in family medicine is social exchange of two equal experts:

A Person centred approach
B Person centred consultation
C Partnership relation
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- **Patient** - expert in his experience of disease (other diseases), with own ideas, feelings, fear related to the existing problem, expectations, possible plan how to manage the problem
- **Doctor** – expert in evaluating (bio-, psicho-, social-) aspects of patient's problem and expert in managing problem, applying evidence based methods and motivating patient to develop new management plan, to change behavior, etc.

Consultation in family medicine

A Person centred approach
B Person centred consultation
C Partnership relation
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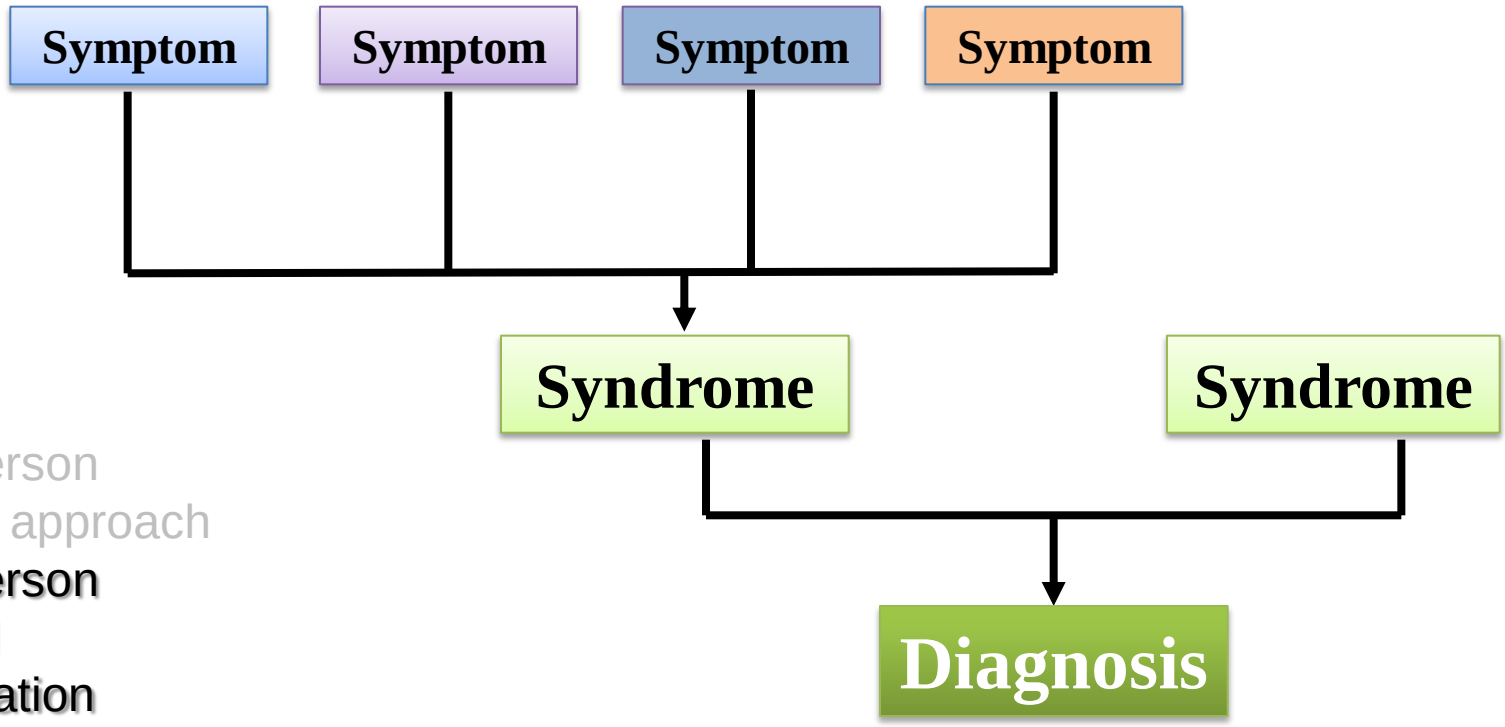
Biomedical approach

- Trained to diagnose and treat diseases
- Fragmented education
  - Extensive training of anatomy… histology…physiology… pathology…clinical …
- Monocausal way of thinking
- Emphasize on biological factors
- Quantitative terms and methods

Diagnosis oriented approach



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Consultation in family medicine

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Holistic (bio-psycho-social) model

Georg Engel, 1978 – "The need for a new medical model: a challenge for biomedicine"

- More comprehensive understanding of a disease requires additional concepts
- Consideration of psychological, social, cultural factors (symptoms are experienced and reported by any one individual)

Eric Cassel, 1984

- The person as medicine's object

Patient's experience of the disease

A Person centred approach
B Person centred consultation
C Partnership relation
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Folk Model

What has happened ?

Why ?

Why to me ?

Why now ?

What if I do nothing ?

What should I do ?

Who should I see to help ?

Complex consultation

- **A**
  Management of presenting problems
- **B**
  Modification of help-seeking behaviours
- **C**
  Management of continuing problems
- **D**
  Opportunistic health promotion

A Person centred approach
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Stott NCH, Davis RH. J Royal Coll Gen Pract 1979; 29

Approach based on patient’s needs

A Person centred approach
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- To identify what the patient thinks about his illness and his expectations from the meeting with the doctor
- Patient’s concerns for his problem - to identify emotions and to respond appropriately
- To identify the possible patient's action plan and to help him to change this plan (not identical with recommendations)

Family doctor's tasks during consultation

D. Pendleton

A Person centred approach
B Person centred consultation
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1) To define the reason for the patient's attendance;
2) To consider other problems;
3) With the patient, to choose an appropriate action for each problem;
4) To achieve a shared understanding of the problems with the patient;

Family doctor's tasks during consultation

D. Pendleton

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5) To involve the patient in the management and encourage him/her to accept appropriate responsibility;

6) To use time and resources appropriately;

7) To establish and maintain a relationship with the patient which helps to achieve the other tasks.

Tasks oriented on patient

A Person centred approach
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- **A patient centred method focuses on four principal dimensions of patients' experiences:**
  - feelings about their illnesses, especially their fears; the impact of their problems on functioning;
  - their ideas about what is wrong with them;
  - effect of illness experience on daily activity;
  - their expectations about what should be done

Calgary-Cambridge Guide (revizia 2004)

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Basic five aims of medical interview :

1. Initiating the session
2. Gathering information
3. Building relationship
4. Explanation and planning
5. Closing the session

Providing Structure

- making organisation overt
- attending to flow

Initiating the Session

- preparation
- establishing initial rapport
- identifying the reason(s) for the consultation

Gathering information

- exploration of the patient's problems to discover the:

☐ biomedical perspective ☐ the patient's perspective

☐ background information - context

Physical examination

Explanation and planning

- providing the correct amount and type of information
- aiding accurate recall and understanding
- achieving a shared understanding: incorporating the patient's illness framework
- planning: shared decision making

Closing the Session

- ensuring appropriate point of closure
- forward planning

Building the relationship

- using appropriate non-verbal behaviour
- developing rapport
- involving the patient

1. Initiating the session

A. Establishing initial rapport:

- Greets patient and obtains patient's name
- Introduces self and clarifies role
- Demonstrates interest and respect, attends to patient's physical comfort

Kurtz SM and Silverman JD (1996) Medical Education, 30, 83-9.

1. Initiating the session

B. Identifying the reason(s) for the consultation

- Identifies the patient's problems or the issues that the patient wishes to address with appropriate opening question (for ex. "What problems brought you to the doctor?")
- Listen attentively to the patient's opening statement, without interrupting or directing patient's response
- Confirms list and screens for further problems (so....; anything else?)

Kurtz SM and Silverman JD (1996) Medical Education, 30, 83-9.

Initiating session - data (1)

- Only ¼ of patients (23 to 28%) completed their opening statement (Beckman & Frankel, 1984; Marvel et al, 1999).
- Most patients who were allowed to complete their opening statement without interruption took less than 60 seconds and none longer than 150 seconds, even when encouraged to continue (Beckman & Frankel, 1984). Patients allowed to complete their opening statements of concerns used only 6 seconds more on average that those who were interrupted. (Marvel et al, 1999).

Initiating session - data (1)

- Doctors frequently interrupt patients, often preventing patients from disclosing all of their health problems. Studies have found physician interruption times vary: from 18 seconds (Beckman & Frankel, 1984) to 23.1 seconds (Marvel et al, 1999). Residents have been found to interrupt patients every 12 seconds (Rhoades, 2001).
- Patients generally have more than one concern (average = 1.2 to 3.9)(Beckman & Frankel, 1984).

2. Gathering information

A. Exploring the problem

- Encourages patient to tell the story of the problem(s) from when first started to the present in own words
- Uses closed questioning techniques, appropriately moving from open to closed
- Listens attentively, without interruption
- Facilitates patient's responses verbally and non verbally

e.g. use of encouragement, silence, repetition, paraphrasing, interpretation…

2. Gathering information

A. Exploring the problem

- Picks up verbal and non–verbal cues

(body language, speech, facial expression, affect);

checks out and acknowledges as appropriate

- Clarifies patient's statements that are unclear or need amplification
- Periodically summarizes to verify own understanding of what the patient has said
- Uses concise, easily understood questions and comments, avoids or adequately explains jargon
- Establishes dates and sequence of events

Gathering information (2)

B. Understanding patient's problems

- Actively determines and appropriately explores:
  - Patient's ideas
  - Patient's concerns regarding each problem
  - Patient's expectations (i.e., goals, what help the patient had

    expected for each problem)
  - Effects: how each problem affects the patient's life
  - Encourages patient to express feelings

Gathering information

- Requires communication skills :
  - Open/closed questions
  - Active listening
  - Encouraging
  - Silence
  - Verification
  - Summarizing
  - Empathy

3. Building relation

- Use appropriate verbal and non-verbal behavior
  - Eye contact, facial expression
  - Posture, position & movement
  - Vocal cues e.g. rate, volume, tone
- Writes notes, do in a manner that does not interfere with dialogue or rapport
- Demonstrates appropriate confidence

3. Building relation

- Do not judge
- Demonstrates empathy and support
- Deals sensitively with embarrassing and disturbing topics and physical pain, including when associated with physical examination
- Involving the patient (during physical examination asks the permission)

Building relation – data (3)

- Better non-verbal communication skills are associated with significantly greater patient satisfaction (Griffith et al, 2003)

- Computer use, verbal interruptions, a knock on the door and beeper interruptions all interfered with effective patient-doctor communication (Rhoades et al, 2001)

4. Explanation and planning

A. Inform the patient giving explanations

- Answer to patient's questions
- Check for understanding

B. Uses explicit categorization or signposting

- Repeat and summarize the relevant information
- Use concise, easily understood statements, diagrams, models, written information and instructions

C. Involving patient in decision making

- Offer suggestions and options rather than directives
- Encourage the patient to take part to planning decision making
- Check if patient accepts the care plan

Explanation and planning – data (4)

- Doctors were found to spend an average of 1.3 minutes of time devoted to information giving in interviews lasting an average of 15.5 minutes (Waitzkin 1985), and overestimated the time they devote to task by a factor of nine (Makoul et al, 1995).
- Nine out of 10 patients do not receive good explanations on proposed treatments or tests (Braddock et al, 2000).
- Concerning information, patients can be divided into ‘seekers’ (80%) and ‘avoiders’ (20%), with ‘seekers’ coping better with more information and ‘avoiders’ with less (Miller & Mangan, 1983; Deber, 1994).

5. Closing the session

- Discuss the possible unexpected outcomes, what to do if plan is not working, when and how to seek help.
- Summarize session briefly and clarifies plan of care
- Plan next attendances
- Final check that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

Closing the session – data (5)

- 86% of interview closures are initiated by the physicians. (White et al, 1994)

- In 21% of closures, new problems arise that were not mentioned earlier in the visit (White et al, 1994).

Risk of consultation fail (1)

1. Shortage of time;
2. Nurse in doctor's consulting room
3. Another person interrupted the consultation;
4. Inefficient contact at the beginning of consultation;
5. Consultation of several persons (mother and child, husband and wife);

Risk of consultation fail (2)

6. Patient comes upset (doctor is irritated);
7. At consultation of “difficult” patients;
8. The patient is expected to be consulted by another doctor;
9. Consultation is carried out in the evening;
10. Communication is hampered by language barriers.

- **Communication with a purpose, accurate, efficient support in the atmosphere all contribute to the effectiveness of consultation.**

About communication:

- Is a double sense procedure :
  - from you to another
  - from another to you
- Communicate even when we **do not** speak.
- Is a procedure by which we **receive** and **send** messages:
  - verbal ← → nonverbal
  - intentional ← → non-intentional

Principles of doctor-patient relation

- Empathy
- Sincerity
- Trust
- Confidentiality
- Understanding

Communication skills, important for consultation

- **For gathering information about the patient and his problem**
- **Appropriate response to patient's emotions**

Nonverbal communication

- Approach
- Touch
- Eye contact or insistent gaze
- Face expression
- Body movement
- Posture

Nonverbal communication

- Head nodding
- Posture (open-closed; relaxed-tensioned)
- Face and body expression (happiness, concern, anger, disgust)
- Voice change - quality, volume

Important skills for medical consultation

- **Reflection**
- **Empathy**
- **Legitimation**
- **Justification**
- **Personal support**
- **Partnership with patient**

Important skills for medical consultation

- Active Listening
- Open questions
- Encourage
- Verification
- Summarizing

Factors influencing communication:

- **Communication subject.**
- **Language**

  lack of language knowledge

  unusual phraseology

  way of talking

Factors influencing communication:

- **Complicated medical topics.**
- **Unwanted themes:**

  sexual diseases psychical diseases

  sexual life oncologic diseases

  unwanted pregnancy abortion

  sterility

Factors influencing communication:

Personal qualities of patient

- Age too young or too advanced
- Opposite sex
- Disorders of perception, speech
- Kinship and friendship

- Acute processes, traumas
- Psychic and psychological particularities :
  - Aggression, excessive demands
  - Displeasure of doctor or price of consultation
  - Dementia, depression, hysteria, phobia states

Personal qualities of doctor

- Age too young or too advanced
- Opposite sex
- Disorders of perception: decreasing of hearing, vision, etc.
- Kinship and friendship

- Professional incompetence
- Specific manners
- Strangeness in behavior

Communication difficulties

- Threats
- Give orders
- Insult
- Interrogation
- Praise for handling
- Subject change
- Directing
- Information concealing
- Putting in foreground of oneself
- Refusal to accept the occurred problem
- Lack of self respect şi toward others

Factors influencing communication:

A Person centred approach
B Person centred consultation
C Partnership relation
D Longitudinal care

- Creating of a environment where the individual feels good
- Trust
- Flexibility of opening
- Mutual respect
- Acceptance
- Self consciousness
- Objectivity
- Goodwill
- Attitude of approval

C O N C L U S I O N

- If you practice and incorporate good interpersonal communication skills into your daily interaction with patients and their families, you will have overcome a huge barrier in the doctor-patient relationship that will ultimately foster that relationship immensely.