PROFESSIONAL SUPPLEMENT
to

HEALTHCARE RELATIONSHIPS: RECAPPING FUNDAMENTALS

OUR GUEST CONTRIBUTOR
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About Shared Decisionmaking

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One might be tempted to claim that patients' acceptance of their doctors' recommended treatment plans, after asking one or two questions about those plans, constitutes shared decisionmaking. It does not. Nor is it shared decisionmaking when doctors, with little or no discussion, go along with patients' wishes even though they may disagree with those wishes. Shared decisionmaking, as described below, requires both doctor and patient to fully engage in the decisionmaking process, to share and discuss information, to work towards consensus, and to reach agreement on a treatment plan.[1] Aspects of each step include:

- **Both doctor and patient fully engage in the decisionmaking process.** This requires that both understand, are committed to, and participate in the decisionmaking process.

- **Both share and discuss information.** Patients draw on their personal expertise to share information about themselves, their expectations and their preferences. Physicians draw on their medical expertise to share information with respect to diagnosis and treatment, including alternate treatments, known risks and possible side effects of each.

- **Both work to build consensus and, ultimately, reach agreement on a treatment plan.** These two steps of shared decisionmaking call for certain competencies on the part of both physicians and patients.[2] Patients need to be able to formulate, express, and discuss their concerns and desires; to access and evaluate information; and to make decisions. Physicians and other healthcare professionals, already skilled in obtaining objective data, need to build skills in obtaining subjective data – because what diseases (and treatment options) mean to individual patients can affect the illnesses they experience in ways that are unique to each.[3] Then, because patients often formulate their preferences in the course of receiving and discussing information; and because physicians, by virtue of their medical authority, can exert undue influence merely by the way they provide information,[4] doctors also need to build skills in facilitating patient empowerment.

Barriers to Shared Decisionmaking

The continued abundance of articles on (non)compliance, along with recommendations for the inclusion of patients in decisionmaking as a means of achieving compliance, is but one indication that shared decisionmaking is not yet a widespread occurrence.[5,6] Regarding actual decision-making processes, one study of medical encounters between doctors and patients, found that neither parties fully shared information or engaged in the decisionmaking process.[7] It further found that many of the participating doctors – whose self-selection could reasonably lead to a presumed interest in communication issues – did not demonstrate the competencies described above. Yet some of these same physicians believed they had engaged in shared decisionmaking.[8]

Barriers to shared decisionmaking include a lack of motivation, time, and communication skills (on the part of both doctors and patients). Motivation will be lacking, for example, if individuals disagree with this form of decisionmaking. Yet, even those who think the process is appropriate may have concerns and beliefs that hold them back. Physicians, for instance, may resist the idea of shared decisionmaking because of constraints they face under managed care and a perception that it requires more time than they have to give. However, it has been shown that when doctors are trained in the necessary communication skills, the extra time required can be minimal. [9] Indeed, early experiments utilizing standardized patients showed that 10-minute encounters were enough for this process.[10]

Patients may also, for varying reasons, be reluctant to engage in this type of decisionmaking process. Social, cultural and language differences may serve as barriers, as may feelings of intimidation in the presence of doctors. In many of these cases, physicians can help by both inviting and guiding patient participation. *See* **Decisionmaking** *on page PS 2*

Decisionmaking, *continued from page PS 1*
Three points address other concerns physicians might have. First, it can be claimed that shared decisionmaking heightens, rather than diminishes, the role physicians play in the decisionmaking process for it calls upon them to steer encounters in ways that are shown to facilitate patient empowerment, self-management of diseases, and improved outcomes.

Second, many patients who question their physicians and/or bring information gathered from outside sources are simply seeking to be partners in their health care and to take the responsibility they are increasingly being urged to take. While some may bring a level of distrust to this task, many do not. Being receptive to all of these patients will enable physicians to distinguish between the two and, where necessary, act to build trust.

Lastly, it is well recognized that shared decisionmaking is not always appropriate. It is seen as called for, however, when chronic or other non-emergency medical conditions require decisions that are potentially life-altering. At the same time, given that practice builds proficiency, the suggestion has been made that physicians and patients begin by trying out this process for some of the more common, less serious, problems.[11] □

[1] C. Charles, A. Gafni, T. Whelan, "Shared Decision Making in the Medical Encounter: what does it mean? (or it takes at least two to tango), *Social Science & Medicine* 44 (1997): 681-692.
[2] Angela Towle et al., "Framework for Teaching and Learning Shared Decision Making", *British Medical Journal* 319 (3): 766+, (Sept. 18. 1999).
[3] J Eric J. Cassell, *Talking With Patients, vol I: The Theory of Doctor Patient Communication,* (Cambridge: MIT Press, 1985).
[4] See Note 2
[5] Donald J. Cegala, "The Effect of Patient Communication Skills Training on Compliance", *JAMA* 283(14):1806 (April 12,2000).
[6] Martha Mitchell Funnell and Robert M. Anderson, "The Problem with Compliance in Diabetes", *JAMA* 284(13): 1709 (October 4, 2000).
[7] Fiona A. Stevenson et al., "Doctor-Patient Communication About Drugs: the Evidence for Shared Decision Making," *Social Science and Medicine* 50 (2000): 829-840.
[8] See Note 7
[9] See Note 2
[10] N.M. Clark et al., "Impact of education for physicians on patient outcomes" *Pediatrics* 101 (1998): 831-6.
[11] See Note 2

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The Importance of Treating Persons

EDITOR'S NOTE: *This article first appeared in the July 2002 issue of the Review, the topic of which was cancer. It followed a lengthy article, 'Adrienne's Voice' by Dr. Dennis Novack.*

"The test of a system of medicine should be its adequacy in the face of suffering." Eric J. Cassell, **MD**
in *The Nature of Suffering and the Goals of Medicine*

One message that Adrienne seems to be sending is that a large part of her suffering stemmed from a sensed loss of identity. This sense of loss, as she describes it, arose in large part from the fact of her illness. Where once she was a person of good health (in all her different aspects), now she was not. For her, as for many others, this loss of identity extended well beyond the physical.

How can healthcare professionals help patients with such debilitating, life changing, perhaps even fatal, identity-stealing conditions? What can they do, when nothing can be done to change the physical effect of these conditions? If Adrienne's voice is to be heard, the simple act of seeing and relating to patients as persons, not diseases, would be immensely helpful.

Cassell makes the same argument. In *the Nature of Suffering*, he builds a strong case that getting to know and treat patients as persons goes beyond leaving them more satisfied with encounters. It can, he claims (as did Adrienne), help patients regain positive self-identities. This, in turn, can serve:

> *...to heal the sick; to make whole the cured; to bring the chronically ill back within the fold; to relieve suffering; and to lift the burdens of illness (p. 69).*□

Actions That Inspire Patients' Trust

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Scales assessing patients' trust in their clinicians have been developed and studies undertaken to identify those aspects of clinician-patient encounters which inspire patient trust.[1-3] Findings indicate that physicians who demonstrate competency and caring are more likely to inspire their patients to trust them.

Demonstrations of competency, as seen by patients, include: thoroughness in evaluation of problems and provision of treatment that is both warranted and effective. Interpersonal skills that demonstrate caring and inspire trust include those that make patients feel that clinicians: are listening to them, and can understand their perspectives; are caring, honest and respectful; are communicating fully and clearly; and are willing to build partnerships and share in decisionmaking. In other words, treat them as persons. □

[1] Birgit Leison and Michael R Hyman, "An Improved Scale for Assessing Patients' Trust in Their Physician," *Health Marketing QuarterlyJ2001).*

[2] LA Anderson and RF Dedrick, Development of the Trust in Physician Scale: a Measure to Assess Interpersonal Tmst in Patient-Physician Relationships," *Psychol Rep:* 67: 1091- 100 (1990).

[3] David H. Thorn and Bmce Campbell, " Patient-Physician Tmst: an Exploratory Study," *Journal a/Family Practice: 44* (2): 169+ (Feb 1997).

The Lament, Hidden Key to Effective Listening

By Barry Bub, MD

EDITOR'S NOTE: *This article first appeared in the Professional Supplement to v5n2, our Summer/Fall 2005 issue of the Review.*

Love is a toil and life is a trouble, Riches will fade and beauty will flee
Pleasures they dwindle and prices they double, And nothing is as I would wish it to be.
Housewife's lament c 19th century

I was introduced to an elderly lady the other day. '*What do you do?*' she asked. '*I teach physicians communication skills*.' I replied. Her retort was painfully blunt. '*Physicians do not listen, and when they listen they do not hear*.'

This comment echoes the virtually general refrain of the public that their physicians do not listen and understand them. The response of the physician population is no less predictable: *'Not enough time.'* Yes, some attempt is being made to teach communication and bedside manners to medical students but then they are reminded in their residency training: *'You are now in the real world.'*

Many physicians do of course find themselves under great pressure and shortage of time is such an obvious issue that this rebuttal may easily be accepted at face value. Careful scrutiny however, suggests that there is far more to this problem than meets the eye. For example, if lack of time is so problematic, why are time management and practice management so rarely taught in medical conferences? Why is there so little collaboration to save time? Why are so many unnecessary and time-consuming surgeries and procedures performed? How much time is actually saved by careful listening and do patients in fact want *longer* listening or are they really asking for *better* listening?

When listening to the person (versus the organ) most physicians function as amateurs not knowing what to listen for nor how to respond appropriately. As a consequence, vital communication clues tend to be missed as are opportunities for healing.

There are in fact many reasons why physicians do not listen well. Most relate to deeply imbedded myths within the profession that interrupt listening. One example is the myth that medicine is an art and a science. With this split firmly in place, what is considered 'science' becomes funded and taught and what is labeled 'art' is often given scant attention. A good example of this is auscultation. Considered science, students are trained to use their stethoscopes for listening to internal organs. They learn for example to identify abnormal from normal heart sounds as well as what to do when they hear an abnormality. When listening to the person (versus the organ) most physicians function as amateurs not knowing *what to listen for* nor how to respond appropriately. As a consequence, vital communication clues tend to be missed as are opportunities for healing. This has been documented by Wendy Levinson and others when reviewing videotapes of physician-patient sessions.[1]

One pervasive narrative theme that is often missed is the lament. People who suffer, complain, cry, mourn, wail—that is, they lament. Usually the lament is vocal, not infrequently however, it is non-verbal with a sigh, a slump of the shoulders, a shrug or a tear. It may be embodied as chronic fatigue or low backache, vague abdominal pain or the condition called multiple functional somatic symptoms. A lament may also be hidden in a cynical comment, a joke, a fixed smile, an angry outburst or it may be born in silence. In other words, a lament is transmitted in many guises. No matter how it manifests however, the lament is always an expression of suffering.

Not surprisingly the word 'patient' derives from the Latin word for 'suffer.' The physical trauma of illness or injury is frequently accompanied by emotional and spiritual trauma, losses and suffering. The old Hassidic quote: 'A small hole in the body, a large hole in the soul" refers to this. Physicians are trained to identify and treat physical pathology, not emotional or spiritual. Laments may be expressed acutely or chronically. Death of a loved one, news of a catastrophic illness or injury may trigger an acute lament with outpouring of emotion. This grief reaction frees up emotions and is the first stage of healing. The appropriate professional response is to make space for mourning and to avoid premature comfort or attempts to demonstrate meaning. Sometimes grief is *disenfranchised*. It is not acknowledged, validated and supported or there may simply just not be enough time to fully mourn. For example a busy executive may suffer a devastating loss e.g. a stillbirth then have to return to work within a few weeks. Mourning is incomplete and grief is buried. When asked how she is, she smiles weakly and responds: 'I'm fine.' She really isn't and grief, having to go somewhere, seeps out in the form of a comment here and there and physical symptoms e.g. chronic fatigue.

Individuals frequently disenfranchise their own grief. I am reminded of a patient who was promoted to supervisor, a position she had wanted for some years. Elation changed to sadness when her former co-workers now excluded her from their coffee breaks and viewed her with suspicion. One day she had to reprimand one former colleague. She came to see me when she began having physical symptoms. Once I made it safe for her to mourn, she had a good cry and together we planned a strategy for her to adapt to her new circumstances.

See **Lament,** *pg. PS 4*

Lament, *continued from pg. PS 3*

Many people lament. Nursing home patients frequently lament their losses by being cranky, complaining incessantly and failing to respond to treatment of their physical symptoms. Indeed, they may have many losses – independence, health, mobility, bodily functions, friends, family, self-esteem, privacy – the list is seemingly endless. Physicians, too, lament in this era of managed care and loss of autonomy. Described as the 'Physician Moaning Syndrome' it can occur wherever physicians congregate. Regardless of the etiology, this chronic lament can be identified by its themes of negativity, loss, hopelessness, helplessness, loneliness and social isolation, nostalgia, absence of meaning, shame, anger, guilt. Like a tape that is played over and over it is often long, repetitive and preoccupied with self.

The chronic lament is mostly counterproductive, alienating rather than drawing others closer. Like a foreign body in a wound, it draws attention to itself and inhibits healing rather than facilitating it. Only when genuine emotion is felt and expressed, can the lament begin to shift into constructive action. In other words, when the chronic lamenter experiences sadness or weeps in the course of talking, this is a positive sign.

Once the listener recognizes that he or she is hearing a lament, the effective response is to empathize with the underlying emotions, validate the losses and to **avoid attempts at fixing the problem**. In this situation, listening is actually therapeutic. This hands off approach, is counterintuitive for physicians since it is very different to treatment of disease. If anything, suggestions might be offered that empower the lamenter and relieve isolation e.g. in the case of the nursing home patient with multiple physical complaints, the physician might validate her losses and then ask: "Since I can't take care of all your problems, how can I be most helpful to you?" This response invites a partnership and the sharing of power.

As indicated earlier, it is not only patients who lament. Caregivers, employees, nursing staff, colleagues and even spouses lament. When physicians learn to appreciate laments for what they are and master effective counseling techniques, then hopefully their frustration will lessen with improvement in their own personal and professional satisfaction and well-being.

Perhaps the time will come when patients such as Jedaiah Berdesi of the 14th century will no longer complain: *"When you are in need of a physician, you esteem him like a god; when he has brought you out of danger, consider him a kin; when you have been cured he becomes human like yourself; when he sends his bill you think of him as a devil."* □

[1] W. Levinson, R. Gorawara-Bhat, J. Lamb. "A study of patient clues and physician responses in primary care and surgical settings. *JAMA* 2000: 284:1021-7.

The Power of Saying 'I'm Sorry'

EDITOR'S NOTE: *This article first appeared in the Professional Supplement to v4n1, our Winter/Spring 2004 issue of the Review.*

Joel Greenberg, a plaintiff's malpractice attorney practicing in the state of Illinois, offers advice to physicians on how to avoid facing him, or his counterparts, in court. In "Conversations With the Enemy," an interview heard on the audio magazine *Second Opinion*, Volume I, Greenberg talks about the power of saying 'I'm sorry.'[1] This is not to be confused, he says, with admitting guilt. He advises against that. But it's okay, even right, he says, to tell the patient that you are sorry things worked out the way they did.

Greenberg reports repeated instances where patients were able to resolve their animosity towards their doctors because those doctors had been good to them and told them what was happening. Despite strong cases, the patients refused to sue. For this reason, he believes: "If you say you're sorry, in a meaningful way, to a patient, you will find the results to be staggering in your favor – as opposed to running away, hiding, evading and not being a real person with the patient." Such advice may feel counterintuitive – and certainly difficult to follow. But one case, described in an email dated October 13, 2001 (Subject: "Honesty, A True Story"), provides valuable insight into why it often works.[2]

In it we learn of a woman who comes out of an eight-day coma after an artery was accidentally cut in a repeat surgery for a post-operative infection. Six years earlier, this woman had reacted vigorously to medical errors:

> *"I was lied to, things were covered-up and everyone denied everything. I felt angry and betrayed. I filed complaints, contacted the media and made a big fuss."*

This time, however, was different:

> *"Will I do the same now…? No. I won't. I'm not angry, nor do I feel betrayed. Everyone was up front and honest with me. My surgeon freely admitted [what happened]…. No cover-ups, No lies. They did the best they could. I survived."*

At least for this patient, transparency made all the difference:

> *"My surgeon has never been sued. I now know why. It's not because he's perfect and has never made a mistake. Everyone makes mistakes sometimes. It's because he's honest and not afraid to admit his shortcomings."* □

[1] Second Opinion, produced and edited by practicing physicians, is exclusively distributed by Connetics Corporation.

[2] Visit the National Patient Safety Foundation at **www.npsf.org**. Follow links to the 'Patient Safety ListServ,' under 'Health Professionals' tab. Scroll down to 'View or Search Archives.'