Communicating with Patients: Guidelines from the Maine Board of Licensure in Medicine

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Each year the Maine Board of Licensure in Medicine deals with a large number of complaints from patients and their families about impersonal, ineffective, confusing, or even misleading communication. They commonly express a need for physicians to establish a more meaningful and useful mode of interaction as an integral part of their care. Physicians typically respond that they (or someone on staff) went through their usual procedures and they frequently but not always offer a rationalization that places responsibility on the patient or her family members. They often express surprise that a complaint had been filed in the first place, indicating lack of awareness about potential problems. We must conclude there is a transmission gap between what the physician (or staff member) presents, what the patient perceives, and what the physician believes has been accomplished in their exchange. Our Board took on the task of exploring this gap with the purpose of developing a set of guidelines to help physicians preempt these complaints by achieving a better quality of interaction that would lead to an improvement of shared understanding.

Approximately one third of cases the Maine Board investigates each year include a breakdown in communication, either as a major issue or at least as a contributing factor to some other issue(s). Recognition of this fact motivated the Board to conceive and disseminate guidelines for Maine physicians with the purpose of reducing the number of complaints of this kind, at least of those reasonably within the physician's control to prevent.

Titled "Communicating with Patients: Guidelines from the Maine Board of Licensure in Medicine," these guidelines are included with the Board's response to each new application and renewal submitted to the Board. The Board also includes a copy of the guidelines with letters of guidance when appropriate, after an informal conference or hearing. The guidelines do not carry statutory weight but they do serve to inform the profession of what the Board considers best practice with regard to establishing personally satisfying, meaningful and useful communication with patients.

In addition, adhering to the guidelines may provide legal protection in some circumstances; in any case, practicing and employing good communication skills is the right thing to do from an ethical perspective that includes but also exceeds legal considerations. It is the physician's obligation to respect *in practice* a patient's right to personally satisfying, meaningful and useful communication that is likely to ensure patients' full participation in diagnostic and treatment recommendations.

It is in this spirit the Maine Board of Licensure in Medicine offers to share its best effort (so far) in guiding physicians along the difficult, and sometimes tricky, path toward shared understanding and full participation with patients of all kinds. The Board's guidelines are reproduced below.

Communicating with Patients *Guidelines from the Maine Board of Licensure in Medicine*

Why Are These Guidelines Important?

Refined skills in communicating with patients have been shown in many studies to produce therapeutic benefits for patients.

It is likewise true that patients who experience satisfaction with their clinicians' sincere attempts at meaningful communication also express greater satisfaction with their medical care over-all.

A practical consequence of this attitude is the likely preclusion of complaints to the Board, and to the courts via lawsuits. A majority of Board complaints about clinicians are related to issues of communication, rather than clinical competence.[1]

1. Competent clinical decision-making is not, by itself, enough. Interpersonal and communications skills are one of the six areas in which clinicians-in-training need to demonstrate competence as identified by the Accreditation Council for Graduate Medical Education (ACGME).

The Board intends these Guidelines to enhance the artful practice of the science of medicine, as shown by this analogy to musical performance: "To become a musician…you need to acquire all the technical skills…the notes, the chords, the scales. This is the *science* of music. But when you *play* music, especially when you improvise, this is the art of music."[2]

Goals of These Guidelines

A primary goal of these Guidelines is to facilitate an increase in comfort and confidence for both clinicians and patients, which then can lead to more satisfactory outcomes in terms of diagnosis and readiness to act in accordance with treatment plans.

A second goal is to increase efficiency in office visits by obtaining a good history that adds *meaning* to the information given (more on this below).

A third goal is to emphasize that, like any skill, effective communication requires practice, reflection, and refinement.

The Setting

The most effective position to assume while communicating with a patient is to sit down at the same level as the patient, in an unhurried posture, showing emotional comfort, while making easy and sustained eye contact.

Sitting in this way is itself powerful non-verbal communication.[3] It leads to a *perception* of added time with the patient (but not actual time). It also conveys an impression of caring, connection, and respect. When this impression is sincere, there is a very good chance the patient will be pleased, even gratified with the visit.

The desk, the computer, and the chair can either be aids or impediments to good communication. In general, it is better not to use a desk to separate yourself from the patient. Likewise, looking at the computer screen while talking with a patient can convey an impression of indifference to the patient *as a person*, rather than as a clinical portrait.

If necessary, given that electronic medical records are ubiquitous, place the computer such that it and the patient are in the same line of sight. This way, shifting focus from the patient to the screen can be done by simply raising and lowering the eyes.

Kinds of Questions

"Everyone nodded, nobody agreed."[4] This outcome is to be avoided at all cost.

Typically, when patients encounter their clinician they want to "begin the story" of their problem, their illness, their suffering. This can be facilitated with an *open question* such as "What's happening; what's going on?" Some patients may be reluctant at first and will need gentle prodding; don't be in a hurry. Once the story has been told, the clinician can ask, "How can I help?"

On the other hand, clinicians often want to hear "the chief complaint," and fear the patient's story will take too long to tell. Research shows this fear, in almost all cases, is unfounded. On average, telling the story takes approximately 150 seconds (two and a half minutes). However, given the pressure of time (and perhaps a subconscious reluctance to give up control), there is an urge to interrupt the patient with a question, which can leave the patient feeling cut-off and that the clinician is not really interested in the background and context of the problem, which might eventually prove to be essential for a correct diagnosis.

How a question is framed will affect the answer offered.

2. Danielle Ofri, MD. W*hat Patients Say, What Doctors Hear.* Beacon Press, 2017.
3. Nonverbal communication (e.g., body language and facial expressions) occurs throughout a patient encounter. Clinicians are trained to observe and evaluate patients' nonverbal cues. A clinician's nonverbal cues can convey *to the patient* a sense of attention or caring or a sense of impatience and indifference.
4. Ian McEwan. *Amsterdam*. Doubleday, 1999.

Sometimes starting a question with "Why…?" can sound critical or inquisitorial, and therefore should be avoided. Patients can be expected to *describe* (what) rather than to interpret, or explain (why). The latter is the clinician's job.

Likewise, *closed questions* that require a specific answer (a Q & A list of symptoms aimed at Yes or No answers) leave little room for qualification or explanation, and when asked in rapid succession can be so taxing as to preclude precision in response. This is especially important to keep in mind when the patient is feeling vulnerable due to anxiety or pain.

Leading questions: "Did you then take the pills as prescribed?" is a leading question. This form can introduce bias and be misleading. Objectivity (accuracy and precision) is compromised by leading questions.

After discussing a medical situation, asking a patient "Do you understand?" can actually be threatening. Admitting a lack of understanding can feel like exposing ignorance — nobody wants to do that. So, that form of question might well elicit a nod of agreement, when there is no agreement.

With all these caveats, what is left? Open questions (i.e., "What did you do then?") that allow the patient to tell the story of the problem, followed by requests for clarification and elaboration, followed by the "teach back" technique; that is, asking the patient to express a personal understanding of the conversation, along with desires, and expectations. This form of question does not carry the same threat potential that comes with "Do you understand?"

Kinds of Listening

Consider this anecdote from an astute physician: A wise senior partner told me when I was starting, "You will know the diagnosis within a minute of entering the room. Restrain yourself from triumphantly announcing it. Instead, sit down and listen to the story. Even examine him/her whether you need to or not. He/she has come less for the diagnosis than to be seen and heard. And who knows, you might find out that your first impression was wrong."

There is a useful distinction between two kinds of listening:

1) Keenly focused attention with regard to the technical/medical concerns of the *listener*: like recording post-surgical details. This is related to a closed Q & A list of questions.

2) Empathetic attention with the aim of assuming the *speaker's* perspective: like identifying with a character in a novel or a movie. This is related to the open narrative type of question.

In the first kind of listening, if what is heard does not fit within what is already known and familiar, it may sometimes be discounted or ignored.

The second kind of listening is deliberately drawn to anomaly, to the descriptive details and explanations that make the speaker unique as a person who is also a patient, or make the situation unique because *this* person is in it. (The anecdote above is about this kind of listening.)

Failure to recognize the anomalous (unique) patient can usually be traced to the clinician's skills and style of listening. Luckily, the skills of empathetic understanding can be improved simply and without cost (except in terms of time set aside for the purpose). Start by engaging a partner who is willing to sit with you and explain something of personal importance. Attend to what is offered and do not interrupt except to clarify your understanding of a word or expression. At certain junctures, ask to paraphrase in your own words what you believe you have heard. Repeat until the speaker can certify your understanding by saying something like "Yes; that is what I mean. You understand."

This exercise takes time because first impressions or first interpretations are often only partially correct. They need refinement to capture subtlety; that is, to become accurate and precise.

Accuracy and precision in understanding what a patient is saying can be more than helpful in diagnostics and treatment planning.

If a good scientific clinician is one who seeks, acquires, interprets, and understands all data relevant to diagnosing and treating a given condition, and if empathetic understanding offers access to more of these data that would otherwise be unavailable, then the clinician who has developed skills of empathetic understanding is a better *scientific* clinician, as well as a more adaptable one. Just as important, the clinician who listens empathetically conveys that she/he cares about the patient.

Kinds of Explanation

It is important to distinguish between two useful but distinct kinds of explanation. The first is *scientific* explanation, which is making a case for why certain events are the way they are and for predicting future events. The second is *semantic* explanation, which by contrast is making the meaning of something clear to the listener. Semantic explanation is like translation or paraphrase, using different words and terms until the intended meaning is revealed and understood.

An explanation can be *satisfactory* (to the clinician) from a formal (scientific) point of view, while at the same time failing to be *satisfying* from the patient's point of view. Another way to put this point is that while a medical explanation of risks and benefits associated with treatment options can be scientifically sound, the listener may find it to be unintelligible, and therefore not useful as information upon which to grant or withhold consent, or even to comprehend what to expect, or what to do.

Self-Evaluation

Be aware of the "Lake Wobegon Effect": a town where "all the children are above average."

There is a common tendency for clinicians to overestimate their communicative effectiveness. It is helpful to be aware of one's personal style and when it may not be working. "Inappropriate humor" can be particularly damaging to relations with patients and their families.

Self-review of interpersonal behavior, often with the help of a colleague (especially including nurses) takes a bit of humility, but it can be enormously helpful. Nurses have more frequent incidental interaction with patients who might reveal to them misunderstandings, particular needs, and reactions. Nurses can be a rich source of information about how to communicate with individual patients, and to interpret their non-verbal signs.

Extension to Other Persons and Situations

While these Guidelines have been focused on clinician-patient interactions, they can with similar benefit be applied to conversations with colleagues, nurses, other staff members, patients' families and advocates, and even, should it come to that, with Board members.

Plenty of research shows that a higher quality of communication skills and effort leads to higher quality in patient outcomes, and interpersonal relations generally. ■

About the Author

David Nyberg, PhD, served 12 years as a public member of the Maine Board of Licensure in Medicine, and continues to serve the Board, as a consultant and as Editor-in-Chief of its newsletter. He is a retired member of the teaching faculty in the Maine Medical Center's Department of Psychiatry, and the author of "Obtaining Meaningful Informed Consent: Guidelines from the Maine Board of Licensure in Medicine," which was published in the *Journal of Medical Regulation* in 2013 (*JMR*: Vol. 99 (3); 2013).