

Findings from Miles Workshops on Physician-Patient Communication

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In 1989, the Miles Inc. Pharmaceutical Division introduced a half-day workshop for physicians that focuses on doctor-patient communication. The workshop, now held under the aegis of the Miles Institute for Health Care Communication, received considerable public recognition (1) and has been repeated nearly 1000 times, reaching over 10,000 physicians across the nation.(2,3) Each workshop begins with a "frustration exercise," in which physicians are asked to name and describe the doctor-patient interactions that they find most difficult. The lists generated by different groups of physicians are remarkably similar. (A typical list appears in Table I.)

Initially, we believed that doctors would identify many varied interactional problems as sources of frustration. We did not expect to be able to resolve or even approach these frustrations with a limited number of strategies. In fact, the workshop had been designed not to find and fix interactional problems, but to give the participants a better understanding of interview dynamics and a model for modifying their own interviews so they could provide more complete clinical care. (4)

To our surprise, we found that a majority of the frustrating experiences workshop participants identified fell into three categories and can be dealt with by three strategies.(5) The physicians experience difficulty when a) patients provide their own diagnoses or therapeutic ideas, or provide a number of complaints, or seem to speak in a different language than the doctor-desired factual telling of symptoms (table II); b) patients express strong negative affect, usually anger or fear or grief (table III); and c) the interview seems to be going badly but the doctor has no tool to help approach the difficulty (table IV). We believe that these frustrations can be dealt with by three corresponding strategies: a) simple awareness of the ubiquity of common communication syndromes; b) effective empathic communication (6); and c) a process in which the physician acknowledges the difficulty he/she is experiencing.

We try to teach these three strategies and end the workshop with a communication-consultation exercise. In this exercise, participants attempt to use these strategies to consult their peers, working on cases previously identified in the "frustration exercise."

THE COMMUNICATION-CONSULTATION EXERCISE:

Participants are grouped in threes or fours. Each participant is asked to take five minutes to write the outlines of a frustrating doctor-patient interaction that he is currently experiencing. They detail patient facts, the patient's problem, the physician's problem, unsuccessful strategies to communicate, and the current status of the relationship. Then, choosing one participant's case to begin, that physician spends a few minutes telling his group these details. Each group member is allowed up to two questions of the presenter and then the "consultant team," the other members of the foursome, get down to business, discussing the communication issues of the case. During this discussion the presenter is barred from speaking but listens to the entire five to ten minute conversation. At the end of their discussion the consultant team offers concrete suggestions and the presenter is asked to say what his plans are at this moment. Sometimes the presenter accepts some or all of the suggestions voiced and other times the presenter notes that the discussion led him to opposite conclusions. However, it is rare for a presenter to be left with no plans at the end of this discussion. Although this exercise is highly structured and very time-limited, we believe it can be viewed as a sort of "Mini-Balint Group Event." We usually have enough time to repeat this communication consultation exercise at least once in each group with another member acting as presenter.

PROBLEMS OFTEN NOTED IN P-P-C WORKSHOPS' FRUSTRATION EXERCISES:

A. INADEQUATE AWARENESS OF COMMON COMMUNICATION SYNDROMES.

Example #1. MY CORONARY ARTERIES ARE TOO NARROW.

Dr. Xylom: Well then, Mr. Apple, what sort of trouble brings you to me today?

A: I think I'm having more angina, doctor.

X: How is that?

A: My coronary arteries are too narrow. It's all that rich food I used to eat, I suppose. My heart can't get enough oxygen.

X: You sound like a doctor. I thought I was supposed to be doing the doctoring.

A: I'm sorry, Dr. Xylom. I'm just trying to answer your question.

X: Yes, well I'd appreciate that.

A: (silence)

DISCUSSION: MY CORONARY ARTERIES ARE TOO NARROW

Dr. X., reporting this dialogue, noted that he felt frustrated when his patient provided his own diagnosis. We think it might help the doctor to learn that most patients come to us already considering an explanatory model. The doctor could release his/her annoyance and replace that response with enlightened enjoyment. The interview could sound more like:

X: Well then, Mr. A., what sort of trouble brings you to me today?

A: I think I'm having more angina, doctor.

X: Uh huh?

A: My coronary arteries must be all clogged up. It's probably all that rich food I used to eat.

X: I see. You think that your coronaries are clogged up and causing more angina. I can understand that. But I need to go back a step or two. Can you tell me about the symptoms you are having?

A: You mean the angina?

X: Yes, exactly what symptoms are we talking about?

A: Oh, I've been having a lot of pain.

X: Pain?

A: Yeah. Mostly here under my rib cage on the right.

In fact, the physician who recounted this story was doubly aggrieved. He had accepted his patient's own diagnosis and accordingly missed the symptomatology and thus the diagnosis of biliary colic. This physician was convinced that the patient misled him, and that the patient's self-diagnosis was a sort of punishment for the doctor. His annoyance with the patient for talking "doctor talk" instead of "patient talk" quickly shut off any patient production. He was never able to hear the real story of the disease. Simply accepting the fact that the patient has told us his explanatory model of his illness allows us to absorb his ideas and move on to what we need to know.

B. STRONG AFFECT: NEED FOR EFFECTIVE EMPATHY

Example #2. I CAN UNDERSTAND HOW YOU FEEL (7)

Dr. Cornea: Hello, Mrs. Groan, how are you doing?

Mrs. G: Not so good, doctor. It's been two weeks since my operation and I am not getting better. My eye is still very red and it hurts. I didn't know it was going to keep hurting like this. My friend, Alice, had an operation on her eye and she was fine in three or four days. I just don't seem to be getting better. I'm kind of sorry I had the operation at all. I think I was better off before.

Dr C: [Leaning forward, speaking aggressively and forcibly.] I can understand how you feel, but I think you just have to be more patient. These things take a little while to resolve and we often see post-operative inflammation that lasts several weeks. You just have to be willing to wait a little while longer and keep using the drops I prescribed. It helps to put them in every four hours just as I told you. I have examined your eyes several times and they are doing just fine. There is no reason for you to be concerned. All you have to do is use those drops just as I have told you. This little bit of inflammation is quite acceptable after an operation and I see nothing remarkable in my examination. It doesn't do any good to be impatient and your friend's clinical course has nothing to do with your condition. She might not even have had the same operation. I don't see any reason for you to bring her into the discussion. And I don't think you have to be worried or upset. This is just part of the operative course and you have to let time do its work.

DISCUSSION: I CAN UNDERSTAND HOW YOU FEEL

Dr. C., recounting this interaction, said that she felt upset when her patient was clearly dissatisfied with the results of her operation.

Many of our most frustrating encounters with patients occur when the patient feels angry or sad and we are uncomfortable hearing about that bad feeling. Often it sounds as if we are being blamed for something. Often we ARE being blamed for something. It really is hard for the doctor. This doctor said that she felt responsible for the patient's slow progress, was beginning to hear the distant voice of a malpractice suit, and was annoyed by the patient's lack of appreciation for a job well done.

The first step in handling any emotional topic, whether the doctor feels blamed or not, is to recognize the existence of a strong affect. Then, a pause is usually in order. The doctor may need to stop to consider and may need to ask her patient to stop.

Dr. C: Ms. G., I need to stop to think about this a moment. I need to consider what you've been telling me.

G: Yes, doctor, my eye isn't getting better at all.

C: No, I really need a little thought here. Perhaps I can ask you to pause a moment and let me think.

Then, the next step is to seriously consider the affect observed and to try to name it. Smith and Hoppe (8) detail four subsequent steps in effective empathy: naming the feeling, validating it, commending the patient's efforts so far; and offering support or partnership.

This dialogue might be amended as follows.

Ms. G: ... I think I was better off before.

Dr. C: Let me see. I can imagine that you are feeling worried right now. You are concerned that your eye is still red and painful. You are worried that perhaps something wasn't done right and you are even wondering if you should have had the eye operation or if you should have consulted a different eye doctor. That must feel really worrisome and frightening for you right now. And you have a friend who seemed to get better much more quickly and that worries you too. You are not sure you are going to get better ever and are imagining all

sorts of horrible complications. Is that the way it feels?

G: I guess that's about how I feel.

C: I can imagine feeling just that way. It must take a fair amount of courage and trust for you to come back to me at all.

G: A little, I guess. . .

C: And I admire your courage in telling me how you feel. That's not always easy.

G: I was a little worried that maybe you'd just get mad at me.

C: I can imagine. Well, even though you are quite concerned about your eye, I can tell you how this usually proceeds. Would you like that?

G: That's what I was hoping for.

C: OK. I'd better examine your eye again now. Then let's talk about what we might do best.

And, after an examination that finds no new pathology but reassures her patient, she could go on:

C: Well, you're right, the eye is still inflamed. But I do think it is less so than last visit. We see slow progress like this fairly often and although it isn't as pleasant for you or for me as when the eye improves immediately, still I think it's moving forward nicely and will probably be fine in another two or three weeks. In the meantime the best therapy is to use the drops as I discussed before. Can you do that?

G: I guess I can be patient a little longer, doctor.

C: I'm sure you can. Now I'm content with the eye's progress but would you feel better to consult another ophthalmologist just for an opinion about that?

G: No, doctor, let's just do what you recommended for now. I feel better now.

Any negative patient affect, anger or fear or sadness, is a difficult challenge for the physician. We need to realize though that such an affect is a gift to us. It provides us with an opportunity to build a solid bridge to the patient. Cohen-Cole says that we can rely on the maxim, "when in doubt, empathize." (9) Suchman and Mathews (10) describe this device as a transpersonal or connexional dimension and use Kleinman's term "empathic witnessing." Other authors also emphasize this procedure. Use of this device, effective empathy, solves a large number of the common physician frustrations.(7)

C. PROCESS DISENGAGEMENT: NEED FOR ENLISTMENT IN RE-ENGAGEMENT

Example #3. A HEARING DOG (11)

Bernice accosted the doctor at his reception desk as she saw him passing by.

B: "I need to talk to you about Veronica. She needs a double prescription on all her medicines and a letter for the bus company."

Dr.Phloem: What sort of letter? What's happening?

B: She's going on a vacation. Do you remember how I told you she doesn't hear so well? The bus company will let us take our dog along if you write a letter.

P: I don't understand. How would I tell them to take the dog?

B: It's a hearing dog. It barks if someone talks to Veronica or attacks her.

Together they entered the examination room where Veronica awaited. Veronica is a 45 year old woman with a well known but fairly inactive seizure disorder. She had previously been documented to have a mild hearing loss. Veronica lives with Bernice, a 60 year old woman friend, who cares for her. Both are very large people and Bernice has a loud, aggressive voice.

P: Hello, Veronica. How are you doing?

V: Pretty good, doctor. No problems.

P: Have any seizures since I last saw you?
V: No, no seizures. But a few blackouts.
B: She blacks out.
P: How often?
V: I don't know.
B: Every so often.
V: I don't remember.
B: She had about three last month.
P: Tell me about the blackouts.
V: I don't remember them.
B: She just gets strange and sits there for a couple of minutes and then she doesn't remember anything for about a half an hour.
P: I see. No movements or urinating or anything else?
B: No.
P: I see. Veronica, how is your hearing now?
B: She can't hear things.
V: It's OK.
P: Hmm. Well, let's retest it.

He goes out, returns with a portable audiometer, tests her hearing, revealing the same mild hearing loss as documented six months ago.

P: Now tell me again about the dog letter.
B: We're going to Lubbock for two weeks and the bus company won't let us take the dog unless it is a hearing or a seeing dog so you gotta write a letter.
P: Hmm. I don't know much about dogs for the hearing impaired.
B: That's OK. Just tell them we need it.

DISCUSSION - HEARING DOG

Dr. P. says that Bernice is a known manipulator. She always comes with a story that is designed to achieve some specific action by the doctor. In past years she attempted to manipulate him about issues related to her husband's care and ancillary financial support. Dr. P. says that she is not trustable. He doesn't think that she can be believed. She schemes to achieve her ends as she sees them and does not trust the doctor.

This doctor felt himself to be at his rope's end. He ended their relationship by telling her that he could no longer take care of her or her ward because of the manipulative behavior and because he couldn't trust her. Afterwards he felt a bit guilty that he hadn't offered her a second chance, since he had never before confronted her with the issue of her manipulation. He said that she probably wouldn't have been able to take advantage of a second chance but that he would have felt better about himself if he had been able to offer it. What if their final conversation had been more like this:

P: Bernice, I am really troubled by all this. First of all, Veronica's hearing disorder is nowhere severe enough to qualify. Second, your dog isn't trained to the task. Then, there's another problem, I often notice that you come here with a firm idea of what you want me to do and then try to find medical reasons to convince me of that idea.
B: How else could I do it? You're a doctor!
P: I see your point. Still, I then feel sort of manipulated. I begin to wonder if you trust me and I don't feel entirely able to trust you.
B: OK, you don't have to do what I want you to do.
P: I appreciate that. But I would be more comfortable if you didn't view me like a clerical

service to fill out whatever forms you could find to accomplish your ends. I'd be more comfortable if you could really tell me how you are feeling and not try so hard to get me to do things for you in the outside world.

B: Will you still be my doctor?

P: I'd like to try to be. But I do need you to know that I can't go on as we've been going. It is too hard for me.

This approach might not work with Bernice. However, in many simpler interview derangements, the patient enlistment is simple and appropriate.

For example, to go from the sublime to the ridiculous, consider this dialogue:

Example #4. I CAN'T HEAR YOU

Dr. X: How have you been feeling, Mr. Whisper?

W: Mumble, mumble

X: I'm sorry; I'm a little hard of hearing; I can't hear you. Could you speak louder?

W: Sure, doc. I said I have been fine except for this cough.

Table I

PHYSICIAN FRUSTRATIONS CITED IN A MILES WORKSHOP

1. Patient who brings a laundry list of problems
2. Theorist--patient who gives theories rather than symptoms
3. "By the way"--most important problem surfaces at the end of interview
4. Patient has his or her own diagnosis and wants to convince the doctor of it. "My chiropractor says;" patient brings suggestions from other care-takers, usually those the doctor distrusts
6. Patient comes with plan in mind, perhaps drug- seeking.
7. Patient doesn't follow doctor's instructions, then blames him or her for bad outcome.
8. Rambling narrator
9. Aphasic patient
10. Language barrier
11. Patient abuses doctor's office staff but treats doctor very politely.
12. Nothing has ever helped this person and nothing ever will.
13. Insurance company won't allow referral and patient wants one.
14. Patient calls Friday at 4 pm with a problem that has been present for two weeks.
15. Patient brings wild child who tears apart doctor's exam room while the doctor tries to attend to mother's medical needs.
16. Mother brings one child to be seen but then asks doctor to attend to her three other children whom she has also brought in.
17. Patient wants telephone prescribing.
18. Emergency call. When doctor calls back promptly the patient is out and the doctor has to talk to his answering machine.
19. Compensation case. Accident victim who won't get well.
20. Malingerer
21. Insurance company badgers doctor about admission
22. Ambulance kidnaps patient to another hospital where doctor doesn't have privileges.
23. Child is brought to doctor by babysitter, then doctor has to call and talk to three independent family members.
24. Patient doesn't follow doctor's recommendations, even when he or she writes them out.

- 25. Cigarette smoker who wants cure for his chronic bronchitis
- 26. Alcoholic who won't take responsibility for his/her behavior
- 27. Noninformative patient
- 28. Not enough time; doctor is backed up
- 29. Whiner
- 30. Angry, threatening, obnoxious patient
- 31. Parent insists on specific therapy for the child, perhaps the most expensive therapy
- 32. Patient seems to agree with everything doctor says but is unconvinced and then does not comply
- 33. Depressed, somatization patient, refuses psychotherapy
- 34. Passive patient, won't take responsibility
- 35. Chronic illness, no therapeutic progress, patient demanding more from doctor
- 36. Entitled or VIP patient
- 37. Spouse tells the story
- 38. Patient gives different story to different interviewers
- 39. Patient won't talk to doctor. "It's all in my chart."

Table II

COMMON HUMAN HEALTH BEHAVIOR: TO BE EXPECTED AND VIEWED AS NORMAL

- 1. The patient with multiple complaints, presenting as 'laundry list' or 'by the way' syndrome.
- 2. The patient who brings his own explanatory model to the doctor: a 'theorist' or 'diagnostician.'
- 3. The patient who talks about the 'illness' rather than the 'disease.' The illness is presented in a narrative that includes theories of etiology and descriptions of consequences. People are mentioned who seem, to the physician, not to fit in the narrative.
- 4. The patient who does not follow the doctor's advice because he hasn't yet been enlisted in that sort of action, presenting as non-compliant patient, passive patient, 'unresponsible for life style,' 'unwilling to change behavior.'

Table III

STRONG EMOTIONS REQUIRING EMPATHIC RESPONSE

- anger
- fear
- sadness, grief
- agitation
- feelings of entitlement
- resignation, despair
- denial
- ambivalence

Table IV

DERAILED CONVERSATIONS: REQUIRING ACKNOWLEDGEMENT OF THE PROBLEM AND ENLISTMENT OF THE PATIENT

- laundry list, multiple complaints
- noisy environment
- disruptive child
- distracted patient

language barrier
different opinions of diagnosis, therapy, or future course
family member present who has separate agenda
patient agenda that does not match doctor's scheduling conflict, e.g. patient schedules brief appointment and has problems requiring more time
communication equipment faulty or missing: hearing aids, teeth, glasses, etc.
patient tells saga of medical care instead of symptoms
patient has urgent needs, e.g. bedpan
patient takes interrupting phone call
differing expectation: what is the doctor's job and what is the patient's?

PROCEDURES:

I. ACKNOWLEDGEMENT OF THE PROBLEM -- ENLISTMENT OF THE PATIENT

1. Awareness: something is going wrong
2. Full stop. Silence. Think.
3. Think about the problem:
 - a) What's going on inside me? How am I feeling? Why?
 - b) What is the locus of the problem?
4. Decide:
 - a) Do I want to continue with this patient? If so I must make a commitment to working on the relationship problem.
 - b) Do I want to share the problem with my patient?
5. Acknowledge and own the problem.
Ask for help sorting out the problem or fixing it.
6. Don't take `no' for an answer.

II. EFFECTIVE EMPATHY

1. Awareness: there is a strong affect or a patient dilemma present.
2. Full stop. Silence. Think.
3. Name the affect or the dilemma.
4. Validate the affect.
5. Respect the patient's past efforts.
6. Offer help.

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