The Complicated Doctor-Patient Relationship: Part 1

DPMs should not treat foot problems… they should treat people with foot problems.

BY KENNETH REHM, DPM

Editor's Note: *This is part 1 of a two-part article.*

It was September 14th, 1972, the first day of podiatric medical school at The California College of Podiatric Medicine for the class of 1976. Dr. Phil Gardner stood at the podium looking over a class of 125 eager podiatric physicians and surgeons to be.

Dr. Gardner was the dean of the school and was now assigned to give his standard introductory remarks to the incoming class. He was one of those classic professors, the one whose classes everyone wanted to attend. This esteemed professor was animated, articulate, warm, and well loved, admired and respected for his creative and pioneering work. He was an icon in the profession.

Everyone was listening attentively. Shouting out to his audience, the first remarks came when he demonstratively asked the enthusiastic fledgling attendees the quintessential question:

"Who is here today to learn how to treat feet?" He asked the question several times, each time addressing different parts of the audience, looking staunchly into the students' eyes. Everyone raised their hand after each query. He resolutely retorted: "You, and You, and You," each time peering again at the various students in different locations, "are NOT here to learn how to treat feet!!" There was a mass expression of astonishment,

"Gentleman, you are NOT here to treat feet... You are here to treat PEOPLE who have foot problems."
—Dr. Philip Gardner

as the future podiatrists checked their syllabus, appearing as if they were concerned that they were in the wrong lecture.

No, they were all in the right place. They became glaringly aware of this and his unforgettable mantra, when Dr. Gardner forcefully pounded his open hand on the podium and said:

"Gentlemen!," and then pointing at the students in the room, "*You, You, and You are here to learn how to treat PEOPLE who have foot problems.*"

He went on to say that in treating each patient as a whole person, you come to realize that everyone is different and has different concerns. Take the time to get to know your patient. Dr. Gardner stressed that if you really listen to your patient, they will make the diagnosis *for* you. He added, *"Don't forget, gentlemen, when you hear hoof beats, don't just think of horses, also think of the zebras. To your surprise, you will find a lot of zebras."*

Thank you, Dr. Gardner, for teaching me these very foundational aspects of being the kind of professional I aspired to be. Regrettably, however, at some time, somewhere, these fundamental principles of medical practice have become lost, lamented by too many patients, nowhere to be found.

This "old fashioned" approach, as it's often thought of, begs the question as to whether a strong doctor-patient relationship is relevant or even possible in today's healthcare arena.[1] Correspondingly, let's evaluate which is more productive in terms of caring for our patients: seeing many patients on a more external level, that is, addressing the chief complaint only; or treating the whole patient through a patient-centered approach? In an effort to answer this question more effectively, let's first discuss two basic approaches to practicing medicine that have an unquestionable impact on the doctor-patient relationship.

Two Basic Approaches to the Practice of Medicine

The practice of medicine in the United States is currently guided by two basic approaches.[1] The terminol-

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ogy used in recent medical literature describes these two diverse methodologies as the *biomedical* and the *biopsychosocial* models (Figure 1). The biomedical model is physician-driven with the understanding that the doctor is the only one with the technical and scientific knowledge qualified to set the agenda and to control all of the content and structure of the visit. The doctor is in charge and his job is to address the physical problems at hand as though they were pieces on a chessboard.

The biopsychosocial approach, by contrast, focuses on the patient as a whole person. In this model, the patient's experience of the disease is considered foundational; the approach concentrates on wellness, prevention strategies and disease management. A search for the root cause—and how it's related to physical, mental, emotional, psychological and social issues, and in what way these issues interplay—is always at the top of the agenda. The biopsychosocial paradigm promotes a patient-centered stance, emphasizing the value of patient-centered communication (PCC).

The Four Pillars

Patient-centered communication relies on four pillars of physician engagement[2]:

1) Empathy-Driven Compassionate Behavior

2) Active Patient Participation

3) Active Listening

4) Clear and Understandable Communication

1) Empathy-Driven Compassionate Behavior

Developing empathy is a complex skill that enables an individual to understand and feel the emotional state of others. This ability requires mental, emotional, psychological, intellectual, behavioral, and moral faculties that enable one to understand and respond to the plight, challenges, distress and pain of others. This in turn results in compassionate behavior. Compassion is a caring response to the comprehension of another's anguish. Compassion cannot exist without empathy, as they are part of the same stimulus/ response continuum that drives human beings from seeing to action. An emotional bridge is thereby created, driving a connection between people, a force multiplier of good doctor-patient relationships and improved patient resolve in managing a patient's medical condition.[3]

Interestingly, studies have shown that there is a decline in empathy when a perceived or real need for patient detachment and/or reliance on technology exists. This is one of the critical challenges of contemporary medicine—where time constraints, electronic medical records, increased bureaucratic challenges and governmental regulations are perpetrating this trend. Without targeted interventions, care that is devoid of empathy and compassion results in dissatisfied patients who are less likely to comply with treatment recommendations,

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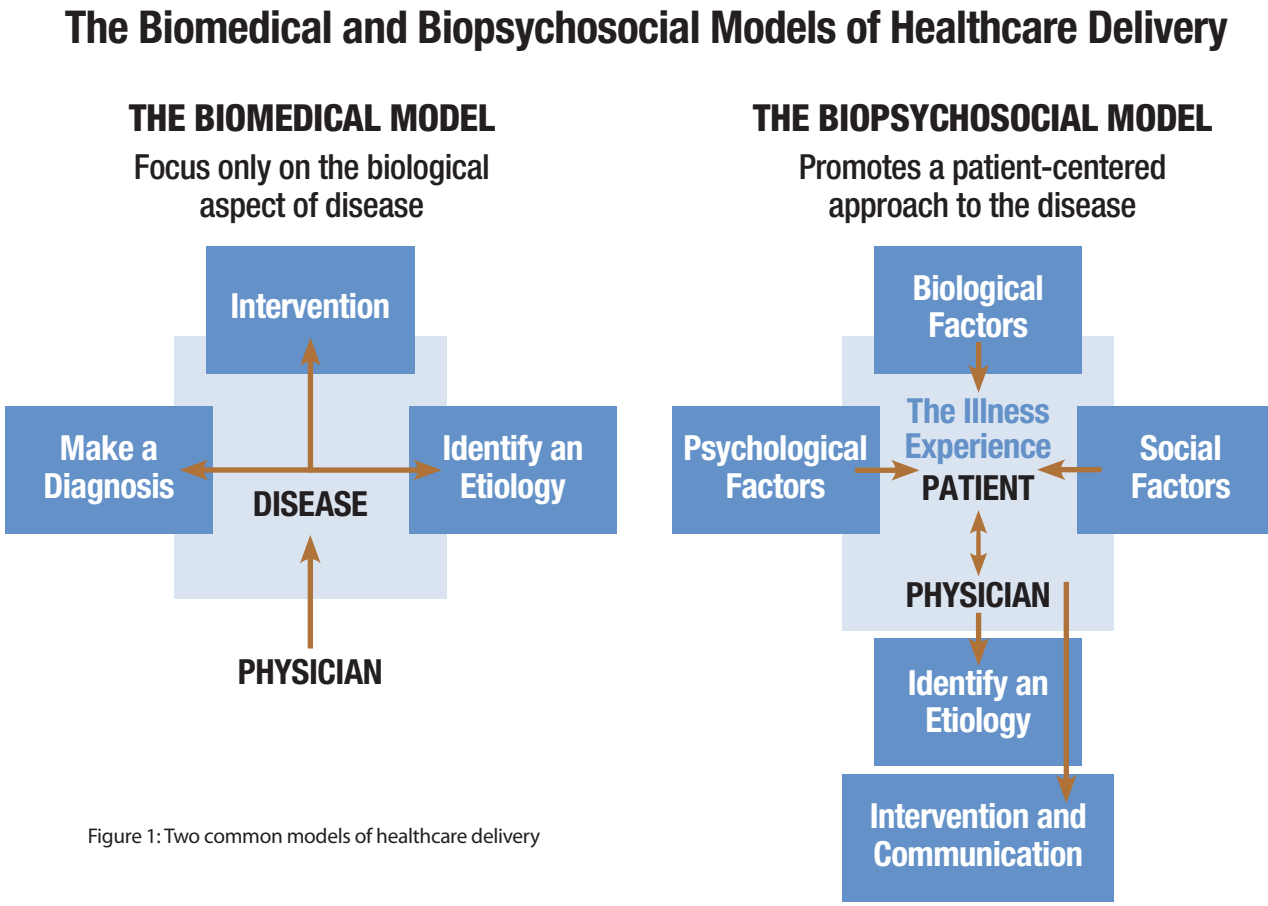

Figure 1: Two common models of healthcare delivery

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resulting in poorer health outcomes and patients who have little or no trust in their providers. In addition, this non-empathetic approach leads to an increase in stress-related problems and other destructive physiological changes in body chemistry.[4]

Moreover, empathy has been largely considered an inborn trait, and this idea has been backed up by solid science—it was thought that it could not be taught. Recent research, however, has shown that this vital human capacity is changeable and can be taught to healthcare providers. When there is a lack of *emotional empathy*, especially due to various biases and preconceptions, then *cognitive empathy* must take over. The key to this behavioral adjustment is in changing the perspective with

If you really listen to your patient, they will make the diagnosis for you.

which the physician looks at the patient. This involves seeing the other person's situation from one's point of view as well as perceiving that individual's importance within one's own life, in addition to developing an increased concern for their welfare. Exploring things you have in common and/or sharing thoughts, feelings, values and concern may indeed open up a highway of interconnection. Empathic medical care is associated with many benefits, including improved patient experiences, adherence to treatment recommendations, better clinical outcomes, fewer medical errors and malpractice claims, and higher physician retention.[3,4]

When considering the subject of empathy as it relates to a good doctor-patient relationship, one must also learn the skill of *empathy attenuation*, however, and not become overwhelmed with another's painful situations. Letting another's anguish interfere with the clinician's energy and judgement is not conducive to a healthy and mutually beneficial doctor-patient relationship. Physicians must strike a balance between empathy and compassion with appropriate distancing behavior which, in turn, fosters a productive healing environment.[4]

2) Active Patient Participation

This pillar requires the physician to be able to know their patient, their level of knowledge, skills, confidence and fears, and to be able to engage patients, at their own level, as partners in their own healthcare. It supports and encourages the patient's role as active participants in their own care, taking ownership of their health and making informed decisions. To accomplish this goal the doctor needs to provide motivation and education with adequate understandable explanations, discussion of the risks and benefits of treatments, and discussion of physical, mental and emotional blocks. This type of communication empowers patients and results in better outcomes.[5]

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3) Active Listening

When discussing the importance of active listening, Dr Gardner's two-part mantra bears repetition: *"If you really listen to your patient, they will make the diagnosis for you;" and " When you hear hoof beats, don't just think of horses, also think of zebras. To your surprise, you will find a lot of zebras."*

In my own history of almost 50 years in practice, both of these assertions have always proved to be true. To actually put them in place, however, requires focused two-sided communication, guided by the physician using intense concentrated listening skills so that an orchestrated purposeful response can be given, using words and intonation to provide careful, precise and intentional meaning conveyed to the patient. Show the patient you care and maintain appropriate eye contact. These assertions should not be relegated as unnecessary and/or unobtainable any more than performing a perfectly precise and exacting surgical procedure would be. These are attainable goals that need to be prominently highlighted in a professional curriculum and prioritized in practice. Active listening skills, like other communication skills, can be and must be learned, and after that constantly developed and perfected, as this skill does not come naturally to most of us. According to the *Harvard Business Review* as stated by Dr. Rana Awdish and Professor Leonard Berry:[6]

The patient must feel relaxed, and s/he must feel that they are in the "right place."

"Modern medicine's true healing potential depends on a resource that is being systematically depleted: the time and capacity to truly listen to patients, hear their stories, and learn not only what's the matter with them but also what matters to them."

4) Clear and Understandable Communication

A physician's primary goal is to be the driver and director of finding, implementing and supporting the diagnosis, treatment plan and follow-through with the goal of attaining solutions to the patient's healthcare challenges. In order for this to happen in an optimum fashion, the doctor needs not only adequate information to make a diagnosis and develop a treatment plan; but also to create an environment that encourages an optimum flow of information from doctor to patient and vice versa, and that inspires the patient's motivation to take responsibility for their own care. This is, however, easier said than done. An environment needs to be created that would cultivate the ideal milieu for the doctor-patient encounter to flourish. The backdrop of this needs to be warm and friendly and is not likely to be traumatic or anxiety-provoking. *Communication* is the key here to creating this optimal atmosphere. It starts with a comfortable room, décor, lighting and seating arrangement that communicates warmth, confidence and trust. The patient must feel relaxed, and s/he must

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feel that they are in the "right place." They should not feel intimated and there should be no additional stressful barriers present that would limit or prohibit open communication. The staff, representing an extension of the doctor, must communicate the same messages. The rest is up to the physician.

There are many models (Figures 2 and 3) that recommend the process that would be in place at this time. They describe various formats for the physician encounter, highlighting what to do to communicate with the patient. No matter what system is in place, however, it must address the requirements for a successful doctor's visit. People in general, and patients specifically, want to be listened to, understood, respected, accepted, believed, valued and to have their thoughts and feelings validated—in short, their concerns and feelings should be taken seriously.[7]

FIGURE 2

Five Fundamentals of Patient Communication

ACTION	DESCRIPTION
Acknowledge	Being attentive and communicate positive greeting
Introduce	Giving your name, role, credentials, reason for visit
Duration	Giving a reasonable time expectation for treatment
Explanation	Giving information such that the patient is informed
Thank You	Demonstrating gratitude to the patient

This is based on the work of Studer Group and AIDET® Five Fundamentals of Patient Communication

In my experience, *how* one communicates has just as much impact as *what* they communicate. The most important factor in how the doctor communicates is their use of words, gestures, tone of voice, and language, and that they demonstrate a nurturing attitude. Asking sincere questions of the patient, showing that the doctor is listening to and hears what is being said, communicates genuine interest in the patient and solving the problem at hand. Next, the doctor must communicate confidence-not just confidence that the physician has an expertise in the subject matter at hand and he or she knows what they're doing, but confidence also that if he or she doesn't know the answers, they will do their best to find out. Thus one wouldn't tell their

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FIGURE 3

The *RESPECT* Model of Patient Engagement

RAPPORT	EMPATHY	SUPPORT	PARTNERSHIP	EXPLANATION	CULTURAL COMPETENCE	TRUST
Develop social connection	Appreciated that the patient has come to you for help	Explore barriers to treatment and compliance	Eliminate any struggles with control. Give it up when appropriate	Ask patient frequently if they understand so far	Look at the patient through the lens of their own culture and beliefs	Patient self-disclosure is difficult in some cultures
See patient's point of view	Seek out understanding of the patient's rationale of thought and behavior	Support patient in eliminating barriers	Don't be stuck on playing a certain role	Use patient appropriate language and clarification	Understand the patient's behavior and impression of you may be defined by their ethnic or cultural biases or stereotypes	Establishing is a gradual process. Develop techniques to gradually establish with your patient
Effort to suspend judgement	Verbally acknowledge the patient's feelings	If necessary, involve family members	"What are ***we*** going to do about the problem?" technique		Be in tune with your own cultural biases and preconceptions	
Don't make assumptions		Assure patient of your availability and desire to help			Be aware of cross-cultural limitations such as language or dietary customs	
					Be able to recognize, adjust or admit that your personal style does not work across cross-cultural barriers	

Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies by the Center for Health Professions, University of California, San Francisco, 2002.

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patient *"There is nothing I can do"*, but rather *"There is nothing I know of that we can do, but I will try my best to find out. Let's keep an open mind."* In other words, they have their In other words, they have their patient's back and will not abandon them.

Asking sincere questions of the patient, showing that the doctor is listening to and hears what is being said, communicates genuine interest in the patient and solving the problem at hand.

The physician should never allow the patient to lose hope. Hope is frequently defined as the belief in or the expectancy of good in the future—and correspondingly, there's the hope of enjoying life in the moment. How the physician communicates a sense of hope is critical, as it allows coping skills to surface and fosters a better quality of life. Even in the context of a terminal situation, hope plays an essential role. Such hope is bolstered by conveying how valuable the patient is in the context of their lives—strengthening and reconciling bonds and relationships with family and friends, helping patients to consider religious and spiritual matters, and controlling their symptoms.[8] Of course one must be transparent and honest with patients, even when delivering difficult news, but one can still be truthful about information and possible outcomes but still be hopeful and kind. Being able to reframe information so that it could be communicated appropriately should be in the skill set of all clinicians.

Furthermore, withholding information or even giving the appearance of being dishonest, overcharging or not keeping your word can damage the trust needed for a good doctor-patient relationship. Additionally, being accessible and offering timely and personal responses to phone calls and messages communicates a sense of reliability and trustworthiness. Communicating respect for the patients' cultural values and preferences, too, goes a long way in building strong doctor-patient relationships.

Dr. Bernie Siegel, in his book *Love, Medicine and Miracles,* notes that "As a surgeon, you can kill or cure with a sword or scalpel but you

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can also cure or kill with words." He speaks of "stress" and of patients "feeling out of control" as being a catalyst for less than optimal outcomes, as it relates to combating disease. He is convinced of the power of the patient's beliefs, and the effect they have on the patient's therapeutic journey. He is an advocate of communication that uses the power of suggestion, and knows the value of a hug and all that communicates. In essence, whatever Dr. Bernie Siegel writes and lectures about speaks to the power of a favorable doctor-patient relationship. **PM**

Part 2 of this article will appear in PM's September issue. **PM**

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