MAKING AN ENTRANCE
RELATIONAL MEDICINE

HOW WE RELATE TO OUR PATIENT IN THE PHYSICIAN TO PATIENT RELATIONSHIP

A facilitative exploration of the art and social aspects of medicine pertaining to improved communication.
Objectives:

1) To analyze and improve the Physician-Patient relationship

2) To discuss ways to improve physician communication skills

3) To define and discuss current barriers to care and to evaluate ways to overcome these barriers
THE MOST IMPORTANT THING IN PATIENT CARE:
The care
• CONNECTION
• RELATIONSHIP
• OVERCOME BARRIERS
  • PHYSICIAN BARRIERS
  • PATIENT BARRIERS
• COMMUNICATION SKILLS
CONNECTION:
THE ART OF RELATING TO OTHERS
Learning from history

Looking backward to think forward

Appropriate communication and connecting as ways of improving physician effectiveness
CONNECTION

Using conversation to connect and relate to one another
CONNECTION:
Why?

- Improved practice experience
- Better patient compliance
- Less Malpractice
How Do We Connect?
CONNECTION:
How?
Through the art of conversation.

- Read the Newspaper
- Sports
- Books
- Employment
- Politics and Religion
- Common hobbies and activities
- The Weather
Relationship
A look into optimized relating in physician—patient interaction
Patient History

Each patient is a person; much more than their past medical history.

Discover “the rest of their story”
Physician—patient relationship

• A relationship will develop as a natural consequence of connecting

• Relationships require boundaries

• In this relationship, barriers will need to be overcome to improve health of the patient

• It is part of the “why” we do medicine
BARRIERS TO CARE

Both patients and providers can be or cause obstacles in the patient-physician relationship.
PATIENT DOMINANT BARRIERS
Physician/patient relational barriers:

Patient barriers

- Language
- Reading/writing level
- Mood/pain level/addiction/seeking behavior
- Cultural beliefs
- Internet
- Cell Phones
- Hearing
- Dominant fallacies of the day
Language

- Foreign language speakers (i.e. Spanish), and accents.
- Learn medical phrases
- Google translate
- Patient or physician provided translator
Reading/Writing Level

• Not everyone reads or writes
• Speak to education level
• Speak to level of medical knowledge
In-room
Distracting behavior

- Manic episode
- Psychotic episode
- Depressed mood
- Anxiety, office phobia
- Pain
- Medication seeking behavior
Split Parenting

- shared physicians
- shared animosity
- shared dysfunction
Cell Phone use
-the distracted patient
I'm having trouble hearing what people say to me.

Maybe you need a hearing aid?

How could a lemonade help?
Cultural barriers
Cultural barriers

• Can be either physician or patient barrier
• Mutual Respect of each other’s cultures
• Recent move = Culture shock/bereavement
• Dissimilar beliefs or backgrounds does not equal hatred or intolerance
Patient barriers; patient bias

- 60 years of McDonalds commercials.
- Quackery
- Belief in neutraceuticals, anti fungals, oils, and other alternative health care options in exclusion of medicines
- Religious bias
PATIENT BARRIERS:
Societal fallacies: modernity, undistributed middle
No-Vacc

- Modernity fallacy—a belief or belief system that claims the modern “thing” takes precedence over science or historical beliefs—with no basis on facts or truths

- A difficult barrier to overcome.

- Can use history, stories, science, and if all else fails, office based rules
How to resolve patient related communication barriers

- Have patients provide translator (i.e. daughter or spouse)
- Learn medical Spanish
- If all else fails—Google translate
- Verbally instruct as well as write instructions
- Signs discouraging cell phone use, or frank discussions
- Encourage hearing aid use in office
- Hearing devices available in office
- Speak at patients level of education
PHYSICIAN BARRIERS
Physician to Patient relationship: Physician Barriers

- Be with your current patient
- The eleven second interruption rule
- Beware of wishful thinking
- Don’t use medical school terminology
- Lack of preparation
- Fatigue/burnout
- Uncaring attitude
PHYSICIAN BURNOUT
PHYSICIAN

Burn Out
What is the problem?

What is the solution?
Causes
1) “paper” work
2) Balancing life

Ways to Improve?

Exclusive Results: 2019 Physician Burnout Survey

Have you felt burned out from practicing medicine at any point during your career?

- NO 8%
- YES 92%

Do you feel burned out right now?
- YES 68%
- NO 32%

What has contributed the most to your feelings of burnout?
- Too much paperwork and government/payer regulations 37%
- Poor work-life balance/work too many hours 19%
- EHRs 17%
- Lack of autonomy/career control 9%
- Insufficient pay/declining reimbursements 7%
- Overwhelmed by patient needs 5%
- Non-adherent patients 1%
- I don't feel burned out 5%
Physician Mood

- Depression
- Mania
- OCD
- Anxiety
- Adjustment disorders (situational issues)
- Divorce, etc.
- Substance abuse
Good Physician

Bad Day......

Or

A lot of bad days...
The distracted doctor

- Maintaining concentration on the current patient
- Avoiding wishful thinking (i.e. because you like a patient)
- Projection; thinking a patient may have something because you have seen someone else have it.
11 Seconds: How Long Your Doctor Listens Before Interrupting You

Bruce Y. Lee Senior Contributor

Healthcare

Time Constraints

And the 11 second interruption
Physician to Patient barriers:

PHYSICIAN PRIDE
(Thinking you are the inherently better)
A DOCTORS CASEBOOK
IN THE LIGHT OF THE BIBLE
BY PAUL TOURNIER
TRANSLATED FROM THE FRENCH, BY EDWIN HUDSON

...say a combination of physical and psychic—\_
\_
\_

He will then be no longer merely a case...
Pride, the thinking of yourself as better than others, will be recognized by others, and has a negative impact on both the listening and respect required in the Patient-Physician relationship.

—Paraphrased and adapted from Paul Tournier
PHYSICIAN PRIDE AS A BARRIER TO CARE

• PHYSICIANS PRONE TO PRIDE, WHY?
  • Higher education
  • More knowledge does not make you a better person than your neighbor
  • Pride can cause you to overlook boundaries
“Perhaps the best way to examine the ‘patient-physician relationship’ is to prioritize each word in the phrase. Ideally the most important word is ‘relationship.’ The second most important would be ‘patient,’ and the third and least important is ‘physician.’ In fact, if the physician puts himself above the other two the relationship is lessened. This is the essence of the medical profession being defined as a service industry”
PHYSICIAN

Inappropriate behaviors
WHEN APPROPRIATE BOUNDARIES ARE NOT KEPT

- Bluffton, Delphos Columbus, OSU, Michigan state, Lima, Findlay....
The past few years the news has been full of physicians that have overstepped bounds. A wife is killed in Cleveland, **Cytotec** is slipped into a water glass of a pregnant girlfriend, Olympic gymnasts are taken advantage with inappropriate sexual touches. Physicians are kicked off of the staff because of inappropriate bullying type of behavior to other hospital personnel. These are all things that have been done to physicians in the local area over the last forty years. Why do physicians think they can get away with this kind of activity? A very large portion of the reason is the pride inherent in years of self training and then being placed in a position where you are in a position of power or authority for people who are sick or in pain or some other kind of vulnerable condition.

The cure for self pride is respect for others. When you recognize that pride for others is essentially respect and start
Physician-Patient Boundaries/boundaries

- Inappropriate boundaries as a barrier to care
- Chaperones
- Don’t do anything you wouldn’t do if your spouse was in the room with you
- Patient discharge
The unnecessary use of medical terminology

“You have an intermittent malfunction and dysmotility of the gastrointestinal system promoting the expedient and rapid transit of the partially digested food bolus resulting in intermittent diarrhea alternating with constipation and flatulence...”
THE OPPOSITE SIDE OF THAT COIN

*Simplification to make verbiage understandable*
Depersonalizing/institutionalizing

- Factors in depersonalization
  - Hospitals, institutionalize
  - Corporate ownership and corporate rules
  - Hospital room number
  - Naming a condition not a patient
  - The use of the passive tense
  - Concerns for HIPAA
Physician negativity

- Learned in medical school from mentors
- Negativity is contagious
- "Negativity bias"
- The abused abuse, the loved love, and everything in between;
  - The power of suggestion
  - If you are optimistic, the treatment is more likely to work.
NON-PROVIDER,
NON-PATIENT
Barriers to Care
INSURANCE
Refusals to pay or certify.
COST

As a barrier to care
Cost

- Pharmaceutical cost
  - Good Rx, generics, otc’s, foreign meds
- Prior authorization
- Stay on formulary
- Pre-certification
- Document, document, document
COMMUNICATION
Improving office communication skills
Improving office communication skills

- Tools of nonverbal communication:
  - Maintain eye contact with the patient
  - Positional similarity
  - Facial expressions
  - Verbal and written communications when possible
Written instructions

-any given patient will remember about 1/4th of what is said during an office visit
Improving Office Communications

- Tools of verbal communications
- Empathy—understand feelings
- Sympathy—shared feelings
- “So what you are saying...”
Office Communication Continued...

- “I see that you are in pain and…”

- “but” negates

- Work together toward a common goal

- “Let’s figure out together what will work best for you”

- And...There is also a time for old fashioned Paternalism, but it is mostly the exception
Communication with children

- Remember the basics—speak simply but not “down to”
- Stick your tongue out at me, LIKE THIS!
- Distraction works wonders. Make noises. Look for smurfs, etc.
- This doesn’t hurt me...this doesn’t hurt your mother.
- Examine babies while mother is holding, as much as possible.
- Everything important is learned in kindergarten.
  - Smiling, Laughing and singing are acceptable!
Entrance and Exit strategies

- Entering the Room
- Review chart before entering room
- Exiting the room
- “Any other concerns”
- Summarize visit
The Oath

Oath

Osteopathic

Oath was adopted by the osteopathic medical profession in 1954.

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature’s laws and the body’s inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it be asked of me.
not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still.
The Oath

Hippocratic Oath - Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.
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OBJECTIVES
Revisited
Sources

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