CHAPTER 2

Interpersonal and Communication Skills

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OBJECTIVES

At the conclusion of this chapter, the student will be able to

1. Understand the importance of proper mindset prior to seeing patients
2. Recognize personal prejudices that may inhibit quality patient care
3. Distinguish between open-ended and closed-ended questioning and know when to use each during the patient interview
4. Identify components of each skill set of the Humanistic Domain
5. Incorporate Humanistic Domain skills into patient encounters
6. State interviewing techniques that demonstrate respect for the patient
7. Demonstrate professionalism in actions
8. Define Health Literacy
9. Tailor education and instruction of the patient to age, level of socioeconomic status, level of education, ethnicity
10. Recognize the goals and tools of cultural competency training

KEY TERMS

Patient interview
Mindset
Prejudice
Humanistic Domain
Verbal skills
Open-ended questions
Closed-ended questions
Listening skills
Respect
Empathy
Professionalism
Confidence
Confidentiality
HIPAA
Medical ethics
Health Literacy
Culture
Cultural competency in health care
Cultural humility
Ask Me 3
4 Cs


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The Patient Interview: More Than Asking Questions

Gathering the medical history from a **patient interview** is not simply asking questions and receiving an answer. Interpretation of the patient's true complaint requires intuition and the skill to observe as much of what is *not* said as of what is. Interviewing therefore truly is an art. The asking of questions may in fact be the easiest part of the interview. A detailed, thorough history can be obtained through the use of memory tools, and the area requiring the most deduction will be the symptoms associated with the primary concern of the patient. Heightened skills of observation, where the patient's nonverbal response is assessed as much as the uttered word, allow the provider a depth of understanding far beyond that of data collection.

Patient interview: the process of gathering historical data surrounding the patient's medical concern while employing humanistic principles

Gaining the trust of patients and encouraging them to become invested in their own care require humanistic skills that infuse the brief encounter shared between you and your patient with empathy, respect, and professionalism. This can be no easy feat to achieve with the pressures of time-limited patient encounters. As we practice medicine and become intimate with its daily needs, we must guard against the drift of complacency and avoid the shortcuts we are tempted to undertake. When you have looked in the one-thousandth ear for a routine physical and have found nothing, you will be tempted to remove the otoscopic exam from future physicals. Be assured that the one-thousand-and-first patient will have a cholesteatoma, a destructive ear canal tumor that can result in permanent hearing loss, even intracranial abscess, if not detected.

Your guiding principle should be this: If at the end of your day, you cannot honestly say that you treated each and every patient in the same manner and with the same recommendations as you would wish to see your father, mother, siblings, or children be treated, you have not treated them correctly—assuming, of course, that you like your family.

MINDSET

Long before you enter your patient's room, your encounter has been prejudiced. You were on call last night with sleep being interrupted on an hourly basis. When you rounded at the hospital, one of your patients needed to be transferred to the intensive care unit. You arrived at your office a half hour late, nearly caught up when you had a "no-show," slid behind again with three "double-books," then skipped lunch arguing with an insurance company about the need for an MRI for your patient with a knee injury, as they insisted on a trial of physical therapy while your exam revealed that the anterior cruciate ligament was in tatters. Your day is ending. You have but one more patient and then a stack of paperwork to clean off your desk. You grab the chart. It's a new patient with dizziness. You know the possible complexities only too well. How easy it would be to sink into the depths of despair.

What is the purpose of seeing a patient? Is it not to take care of the patient's needs and address his/her concerns? This may be as simple as a patient needing a physical examination for a driver's license, having a cold, or wanting you to examine a mole that just doesn't look right. Or it may be as complex as fatigue or shortness of breath.

In any case, your goals during the interview are not only to gather information but also to gain the trust of the patient. Gaining trust allows you to gather information that the patient may not otherwise share. This is not achievable by allowing your current mood to paint a morose mask upon your face, slump your shoulders, thin your patience, or cut short your greeting. Your patient has failed to find relief from his pain for many years. He had heard you were different, that you gave everyone a chance, that you were honest, competent, and caring. Will he now think that he heard wrong?

So no matter how bad your day has been, the patient you are about to see deserves your time, patience, sincerity, and empathy. Your **mindset** is indeed that: yours. You must have control of it and be able to reset it at each and every encounter. The key to successfully doing this is mindfulness of one's self, something often easier said than done. A first step is recognizing your prejudices.

Mindset: a state of mind or attitude that influences patient-provider encounters

PREJUDICES

We all bring our personal experiences along with us into the care of our patients. The tendency to do so is unavoidable as these experiences shape our knowledge and character, as a potter molds a vase. Some of these experiences help our patients, as when they allow us to recognize disease or dysfunction through the memory of seeing other patients in similar situations. But some of these experiences have the potential of inhibiting patient care. Take, for example, the family member with addiction. When you spend your life watching the destructive power addiction has, not only on the addict but on those surrounding them, you could easily develop intolerance toward a patient with such a condition. It is our duty to recognize prejudices that we have and aggressively act to prevent them from influencing the patient encounter.

Ask yourself the following questions:

- What kind of people do I avoid?
- What behaviors grind on my nerves?
- What experiences with people have left a bad taste in my mouth?

These are some of the questions that will help you identify patients at risk of being treated in a biased fashion . . . by you. Consciously identifying your **prejudices** is the first step in avoiding mistreatment of these patients.

Prejudices: a preconceived attitude, opinion, or feeling

THE HUMANISTIC DOMAIN

Humanism in patient care focuses on the relationship between the provider and the patient, and in particular the ability of the provider to communicate properly with the patient. The **Humanistic Domain** is the component of the

Humanistic Domain: The component of the patient–provider interaction that seeks to engage the patient holistically through appropriate use of verbal, listening, educational, and instructional skills and the demonstration of respect, empathy, and professionalism

patient–provider interaction that seeks to engage the patient holistically through appropriate use of verbal, listening, educational, and instructional skills and the demonstration of respect, empathy, and professionalism. Communication only begins with the spoken word, but it transcends this basic level of verbalization, requiring mastery of the ability to listen, educate, and instruct your patient at a level where comprehension is achieved to a degree that demonstrates understanding of the significance of diagnosis and intended outcomes of each treatment or nontreatment option. Communication must be woven with the threads of respect, empathy, and professionalism to gain the full trust and investment of the patient in his/her own care.

Verbal Skills

Verbal skills are essential to the ability to obtain a thorough medical history. At the most rudimentary level, one must speak clearly and with a level of volume appropriate to the patient's needs. Recognition of diminished hearing should prompt the speaker to lower the frequency of voice rather than increase the volume, recognizing that high-frequency hearing loss is the most common type.

The patient's level of education must be considered in order to avoid speaking above or below his/her level of comprehension. If one speaks above a patient's level of comprehension, the patient may readily express understanding to avoid appearing unknowledgeable. Use of medical jargon should be avoided. Conversely, speaking below a patient's level of comprehension may result in feelings of undesired paternalism, even belittlement. Should your patient have training in a medical field, use of medical terminology may be appropriate, as it tells the patient that you acknowledge his/her level of education and expect a higher level of collaboration in providing his/her care.

Verbal skills: the ability to communicate with the patient both mechanically and tactically so that the patient is encouraged to concisely disclose his/her medical history

Open-ended questions: questions posed during the clinical encounter that prompt the patient to answer in his/her own words, knowledge, and feelings

Closed-ended questions: questions posed during the clinical encounter that narrow patient responses to "yes," "no," or a specific selection of choices

OPEN-ENDED VS. CLOSED-ENDED QUESTIONING

Verbal skills also include presenting questions in **open-ended** format. Asking the patient, "What brings you in today?" or "How may I help you?" invites the patient to tell their story in their own words. If you were to say instead, "I see you're here for stomach pain," you would immediately limit the response of the patient to that one complaint. The use of open-ended questioning is akin to your patient answering an essay question instead of one in multiple-choice format. For example, "Could you describe the pain?" requires the patient to consider the pain and use his/her own words describe it. When the product of open-ended questions becomes less fruitful, the transition to **closed-ended questions** is appropriate and preserves the momentum of the interview. After several attempts of asking the patient to describe the pain have resulted in "I don't know. It just hurts," it is time to reformulate the question into closed-ended format:

- Interviewer: "Could you describe the pain?" (open-ended)
- Patient: "It just hurts."
- Interviewer: "Could you be more specific and describe what it feels like?" (open-ended)
- Patient: "It just feels really bad."
- Interviewer: "Would you say the pain is sharp, dull, throbbing, burning . . . ?"

This approach of asking open-ended questions and only moving to closed-ended questions allows the patient to choose the descriptive term that fits his/her perception of it most accurately.

THOUGHT COMPLETION

Your flow of thought must be logical and you should strive to complete one line of questioning before moving to another. One answer from a patient often leads to the next question. Never abandon a question for which you have received an incomplete answer. If someone admits to having had the same abdominal pain twice in the past, ask about those past occurrences. When were they? How long did they last? How were they treated? What were the outcomes? The same is true for medications. It is not enough to discern that

the patient is taking a medication for his gout. What is the name of the medication? How often does he take it? How many milligrams at a time? How long has he been on it? Does he have any side effects from it?

Another task of the provider is to keep the patient's narrative in line with the current concern. This may be a challenge when a patient begins to deviate from the current topic. It takes artful redirection to gently guide a patient back to the topic at hand without appearing uninterested or rushed.

VERBAL SKILLS CHECKLIST

- Speak clearly with an appropriate level of volume.
- Lower your voice for patients with hearing loss instead of increasing volume.
- Speak at the appropriate level of education for the patient.
- Avoid medical jargon.
- Begin lines of inquiry with open-ended questions, moving to closed-ended questions only as needed.
- Gently redirect patients who drift too far away from the topic of concern.

Listening Skills

Skills in active listening refer to more than noting an answer to a posed question. In truth, to excel we must listen with our eyes as much as we do with our ears. Nonverbal clues can reveal subtle components of the patient's story and shed light on underlying meaning.

Listening and documenting patient responses set the foundation of the history to be built upon. The first several questions you ask a patient regarding any complaint serve as a starting point for simple data collection. These are used to define the patient's concern and reveal time frames surrounding it, such as the onset of symptoms, how symptoms have changed since onset, and prior history of similar symptoms. Early on, responses to one question should clue the mind to possible diagnoses. The astute listener catalogs the clue and explores associated signs and symptoms.

For instance, a patient presenting with abdominal pain admits that it occurs after eating. The differential may at least include peptic ulcer disease, cholelithiasis, mesenteric ischemia, lactose intolerance, or celiac sprue. Knowing the disease characteristics of each allows the provider to consider each one in an attempt to define which is most likely. In this case, it is not enough to know that the symptom is associated with eating; one should logically ask which type of food is most likely to cause the pain. Upon hearing that milk products are the major culprits, lactose intolerance comes to the forefront, the others not necessarily being discarded, but lessened in likelihood. Further questioning may completely eliminate some possibilities from the differential. This describes the fluidity of building a list of possible diagnoses called the differential diagnosis: a modeling and remodeling of causes of the patient's condition.

Silence often has the unyielding power to force the provider to continue speaking if only to fill the void. As providers first begin interviewing patients, a pause of 15 seconds feels like an eternity. Our minds falter as we worry that our patients will mistake our inability to proceed with a line of questioning for incompetence. We worry that the patient will see through us and think that we haven't got a clue as to what is going on. In truth, we may indeed not know the exact diagnosis, but a list of possibilities is building.

Providers should become comfortable with short periods of silence. As a patient begins to relate the story that prompted his/her visit to you, avoid the impulse to interject too quickly. As long as the patient is relating pertinent information, allow the story to unfold naturally. Should the patient pause, it may not be necessary to pose a new question. Instead, prompt minimization, such as "I see," "That's interesting," or even "Hmm," allows the patient to continue without interruption. Only when the patient's dialogue strays too far from pertinence should you draw him/her back to center by returning to focused questions.

If you find that you need time to consider possibilities, do not hesitate to share your intent with the patient. Saying "Let me think about that" or "I'm considering the possibilities" allows the patient to appreciate your contemplation. If this is presented correctly, the patient will perceive careful consideration of your concern, not a lack of competence.

Listening skills: the ability of the provider to observe, promote, and interpret verbal and nonverbal communication throughout the patient interview

FOLLOW-UP QUESTIONS

Listening skills include being able to perceive clues from the patient dialogue and properly respond to them. When a historical clue is encountered, it must be explored by asking appropriate follow-up questions. Often in our early patient encounters we tend to ask questions and simply record the answers we hear rather than listen to the answer themselves.

- Provider: "Did anything make it worse?"
- Patient: "Standing too long on it."
- Provider: "Did anything make it better?"
- Patient: "Not really."

The provider should have asked what the patient does that requires them to stand for long periods of time. Is it their occupation, modes of travel, or activities of daily living? By following up in this way, the provider will be able to assess if any changes can be made that would lessen the impact of those behaviors.

At some point in all of our careers, we find ourselves asking a patient the same question that we asked but a few short minutes ago. It is not difficult to read frustration and cynicism on a patient's face. The patient may feel that you are mechanically going through a checklist of questions without really paying attention. Indeed, the patient may wonder if you have actually heard a word that he/she has said.

- Provider: "How did this happen?"
- Patient: "I was bit by a dog while delivering the mail."
- Provider: "When was that?"
- Patient: "Two days ago."

Followed later by:

- Provider: "What do you do for a living?"
- Patient: "I'm a dentist. I just deliver the mail as a hobby."

When you find yourself in this situation, acknowledge your mistake immediately: "I'm sorry; I've already asked that question, haven't I?" Attempt to recognize the reason for your lapse. Were you in too much of a hurry? Was your mind racing through symptoms associated with a possible diagnosis that dashed through your mind? Were you simply writing down a response to a prior question and weren't prepared to listen to the answer to the next? Whatever the reason, share it with your patient. Express your regret. Refocus and pay close attention: "I'm really sorry. I know I already asked that question. I'm afraid I was moving too fast. Let me slow down and give you my full attention."

Patients may express concerns regarding a diagnosis or treatment plan vaguely instead of directly. This may especially be true with a treatment plan that was dictated to the patient instead of built with his/her collaboration. The astute provider should be on alert for both verbal and nonverbal clues that suggest a patient may not agree with what he/she is being told. Avoidance of eye contact by the patient despite verbal assurances of compliance should trigger concern from the provider. There are many reasons a patient may avoid discussing concerns.

Disagreement with the presented diagnosis or treatment is one. You explain to your patient that she has a viral upper respiratory tract infection for which you prescribe rest, keeping well-hydrated, symptomatic relief with an antihistamine, and the passage of time. She, on the other hand, knows that she has sinusitis and will not get better without an antibiotic.

Embarrassment may prevent a patient from voicing his/her concerns. When a young mother is handed a prescription for her child, she haphazardly stuffs it into her purse with a look of despair in her eyes. Directly discussing your observation with her, you learn that she has neither insurance nor money to pay for the prescription no matter what the cost.

A patient's doubt of his/her ability to comply with the treatment plan can also play a role. You have just advised your patient with high cholesterol that he needs to eat a low-fat, high-fiber diet and exercise one hour a day for the next three months and then you will recheck his blood work. As a long-haul truck driver who eats his meals on the road and drives for up to 12 hours a day, he knows it won't happen, but he says, "Sure." Had you asked him how he would like to work on lowering his cholesterol, he would have asked for a pill. Do not disregard these vague clues as figments of your imagination.

When you recognize patient or family concerns, discuss them openly. This legitimizes the concern and allows for further discussion of the treatment plan

with consideration of alternatives where appropriate, risks and complications, and reinforcement of expectations of both the patient and the provider.

LISTENING SKILLS CHECKLIST

- Closely observe the patient for use of nonverbal clues.
- Actively model and remodel the differential diagnosis with each answer received.
- Encourage spontaneity of patient storytelling through prompt minimization.
- Recognize and respond to historical clues.
- Collaborate with the patient and gauge his/her responses to treatment plans.
- Avoid repeating questions that were already answered.
- Legitimize patient concerns.

Respect

Building trust begins with mutual **respect** between the patient and the provider. Though each must earn the respect of the other, it may be that the preponderance of the earning of respect is shouldered by the provider. To earn our patient's respect we must demonstrate a solid foundation in medical knowledge, utilize standard of care in our treatment plans, be unbiased in our approach, and show compassion and empathy.

Conversely, respect for our patients must be granted from the outset, given freely and unconditionally. The patient's duty is to retain it. A new patient presents to your office and it is soon evident that he has sought the council of multiple providers before you. He is convinced that exposure to a chemical agent in the military has resulted in his poor health. He is frustrated by the "incompetence" of his prior providers and states that no one will help him get the disability claim he deserves. Despite the urge to paint the patient in negative light, we have the responsibility to begin anew with the patient, offer respect and unbiased consideration. It is not being naive to begin each new patient encounter with this approach. Explaining to the patient that you recognize his/her frustration and that you intend to wipe the slate clean and start at the beginning lays a solid foundation upon which to begin building. This demonstration of regard and consideration defines respect for the patient.

Respect: the demonstration of giving high regard, consideration, politeness, and kindness without bias

Respect as a component of humanism must be genuine. A patient who feels that it is being offered disingenuously will quickly develop distrust for the provider. It is easy to become cynical in the practice of medicine, yet the best physician is one who leaves prejudice at the door while walking through its frame.

Respect begins with politeness. When you encounter a new patient, introduce yourself using your name and title. If you are in training and another provider will be interacting with the patient, clarify that you are a student and explain your role in his/her visit. When greeting the patient, use his/her title and last name, then ask the patient how he/she would like to be addressed. Thanking the patient at the end of the encounter shows that you value his/her time as much as you value your own.

Sensitivity can be shown by demonstrating kindliness. Demonstrate warmth by shaking the patient's hand. When preparing to perform an examination, ask permission from the patient to do so. When finishing an abdominal examination, don't just walk away and tell the patient to sit up, allowing him/her to flounder. Help the patient with any position change regardless of his/her age. Demonstrate concern for the patient's dignity by properly gowning and draping the patient during the examination. If a patient is asked to lower his/her gown to expose the chest for an examination, once the exam is completed the gown should be replaced immediately before moving on to another area of examination. Likewise, cover the lower extremities with a sheet when performing an abdominal examination. This allows the gown to be raised to expose the abdomen while keeping the sheet in place over the pelvic region and lower extremities.

Patient autonomy refers to the patient's right to choose. It is easy for providers to have a tendency toward being autocratic when devising treatment plans: "This is what you have and this is what I want you to do about it. Have a nice day." Respect for the autonomy of the patient has been lost.

For example, when you identify a patient as a tobacco smoker, before you simply advise the patient to quit, you must first ask if he/she has considered

Empathy: verbal and nonverbal expression of understanding, sympathy, and compassion

stopping. They may not have any intention to do so. That does not mean that the topic stops there. It is our duty to then inform the patient of the risks associated with tobacco use. However, once we have done so, the patient's autonomy in choosing whether to continue smoking remains. You may go so far as to ask the patient if you may bring up the topic at each visit as you consider it of vital importance to their health. If the patient would rather that you didn't, you may still intermittently broach the topic but will avoid aggravating or demoralizing the patient by your persistent barrage.

If a patient does expresses interest in quitting, you must explore what attempts the patient has made in the past and how well they worked. Explaining treatment options allows the patient to make informed decisions. Further asking the patient what he/she thinks will work best will lead to the highest levels of success.

Respect for cultural differences and backgrounds must also be displayed. A Middle Eastern couple comes to your clinic. The husband has been explaining that his wife has a cough. You are a male physician and recognize that you need the permission of the husband to examine his wife. He will not allow it. Do you get angry and say you can't treat her without listening to her chest, or do you find an alternative, such as asking your female office partner to perform the examination?

RESPECT CHECKLIST

- Begin each new patient encounter with unbiased consideration.
- Be polite.
- Introduce yourself by name, title, and role.
- Greet the patient by title and last name.
- Ask how the patient would like to be addressed.
- Shake the patient's hand unless prohibited by culture.
- Demonstrate kindness.
- Help the patient with position changes.
- Gown and drape the patient to preserve dignity.
- Ask permission before examining or exposing the patient.
- Respect the patient's right to choose.
- Respect differences in culture and background.

Empathy

Synonyms for **empathy** include understanding, sympathy, and compassion. Empathy can be expressed both verbally and nonverbally. Eye contact is important in developing a bond with the patient. The expression "the eyes are the windows to the soul" reflects on our ability to communicate with our eyes alone. Patients typically like eye contact about 50% of the time, but this should be based on the individual encounter. Elderly patients may desire more, younger patients less. Making initial eye contact on entering the room forges an early bond the patient. Staring at your paper or computer screen as you take notes may make you appear distant, mechanical, and lacking compassion.

To demonstrate compassion and empathy, the provider must not only hear the patient but must listen to what is being said. Mr. Jones had his gallbladder removed last year. Since that time, fatty foods have caused him to have episodes of urgent diarrhea. Twice he has been eating out and couldn't make it to a restroom before soiling himself. Though eating out was a great pleasure for him, he has stopped doing so. Hearing what the patient is saying leads you to diagnose postcholecystecomy syndrome with diarrhea related to the removal of the gallbladder. Listening to the patient, however, means that you empathize with the embarrassment and restrictions in activity and lifestyle that this is causing the patient.

The provider must show genuine interest in the patient's condition. Telling the patient "It's just a cold virus. You'll get better" shows very little investment on the part of the provider. Patients have invested a great deal to come to see you. They have scheduled an appointment, taken a day off work, waited in a crowded waiting room with sick people all around them, remained calm when you were running an hour late, and have waited in the exam room for another half hour. You may be correct that the patient just has a virus that it will run its course in a few days, but there are different ways to relate this to the patient.

Obviously the condition is a concern for the patient. What symptoms can you treat? Does the patient need a decongestant or cough suppressant? Would osteopathic manipulation benefit the patient? Does he/she need a day or two off from work so that the virus isn't spread to others?

Acknowledging the patient's life situation also demonstrates empathy. Eugene has injured his rotator cuff. This condition is aggravated by his occupation as a roofer. You advise Eugene that he needs to take a week off from his work to allow his shoulder to begin healing. He replies, "A week off?! Doc, roofing doesn't happen in the wintertime. If I don't work now, I don't get paid. We don't have sick time."

Your initial recommendation failed to take the patient's life situation into account. Had you instead involved the patient in the decision-making process from the onset, you would not have had to backtrack to try to remedy the situation. Knowing that a rotator cuff injury requires rest and rehabilitation should lead the provider to inquire how the injury will affect the patient's activities of daily living, including work, exercise, recreation, and the ability to care for himself. Investigating these areas allows you to acknowledge and demonstrate understanding of how the current condition affects your patient's life.

Ms. Wagaman is 93 years old and just fractured her right wrist. Did you know she lives alone? Did you ask her how she was going to drive back home and take care of herself once she got there? Ask the patient if there is anyone you can call to discuss her condition and needs. She has three children in town—could she live with anyone while she recovers?

EMPATHY CHECKLIST

- Demonstrate compassion and sympathy.
- Make appropriate eye contact, speaking with the eyes.
- Move beyond hearing the patient—listen to him/her.
- Show interest in the patient's condition, making clear that it is important to you.
- Demonstrate investment of time and concern.
- Acknowledge the patient's current life situation.
- Recognize how the condition impacts the patient's work, exercise, recreation, and ability to care for him-/herself.

Professionalism

Professionalism is a competency that must not only be maintained while providing skillful medical care but also shadows the provider into his/her private life. Epstein and Hundert define professional competence as the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served.[1]

In the clinical setting, patients and their families judge the level of professionalism of their providers largely on the outcomes of the clinical care they receive, how information is shared with them, and how they are treated. The behavior of the provider is also assessed: Is the provider friendly, does he/she appear energetic, does he/she demonstrate respect for coworkers, is he/she overheard in the hallway discussing other patients, does he/she possess an ego? Further, they also base their impressions on their provider's physical appearance.

PROFESSIONAL DRESS

Physical appearance is the first thing the patient sees when you enter the room. Patient impressions of competence in care directly relate to physical appearance. The better-dressed the provider, the higher the quality of care is perceived to be. When required to round on inpatients on weekends for only a few hours, it is tempting for the provider to don jeans and sneakers, slip into the hospital and then back out. Yet those who do are deemed to be less competent than their peers who wear khakis and dress shirts. Adding a tie and dress pants further increases the patient's perception of competence. To be regarded as the most competent, add a clean, wrinkle-free white coat to the attire. Women's clothing should be conservative. Short skirts and revealing blouses should be avoided. Jewelry should be modest, limiting the number of rings, earrings, and necklaces. Facial piercings should also be avoided.

Patients prefer that men who do not have beards to be cleanly shaven. Beards should be well kept. Hair should be neatly combed or brushed. Shorter hair length on men is preferred over longer styles. Heavy colognes, perfumes, and makeup should be avoided.

Professionalism: the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served

Communication with patients often occurs in tight quarters; therefore hygiene is important. This condition is one that may not be perceived by the provider him-/herself. The presence of body odor may be interpreted as lack of self-care. Patients may question the level of care they will receive if the provider seems unable to care for him-/herself. This is not dissimilar to a provider who smokes counseling his patient on smoking cessation. The discussion of malodor may pose an uncomfortable and embarrassing situation between colleagues, but when approached with honest concern and intent to share awareness that may be lacking, benefit can be derived.

CONCERN FOR THE PATIENT

The demonstration of humane concern for the patient begins with kindness. Identifying the patient's medical condition is only the beginning. Eliciting a complaint of pain and ranking it on a scale of severity is simply mechanical if concern is not shown for the findings. Once a component of pain is recognized, validate it directly so that the patient understands it is a priority for you as well for him/her: "Mrs. Green, I can see that you are in a lot of pain. I'll help you as quickly as I can."

The psychological components of the patient must also be considered. A longtime patient of yours, Mr. Kendall, who is 87 years old, just lost his wife of 63 years. Though he is seeing you for monitoring of his high blood pressure, your concern for his loss should share equal importance. How is he coping with the loss of his wife? Is he able to care for himself? What did his wife do for him that he must now do for himself? Does he have the support of family and friends? Has he isolated himself? Beyond grief, is he depressed or even suicidal? Not all of these questions may need to be asked, but the conversation must begin and be tailored to his needs.

Confidence: assurance and belief in oneself and abilities

Confidentiality: the tenent of professionalism assuring that information given by the patient will be kept in strictest confidence and privacy

HIPAA: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was designed to protect the private health information of patients

CONFIDENCE

Patients must be able to discern an air of **confidence** in their provider. Confidence should be displayed but egotism avoided. Displaying confidence is uncomplicated in cases where the diagnosis and standard of care are immediately known. Rarely do providers find themselves without at least some suspicion or a list of possible diagnoses from which to work. Even when a diagnosis is not at hand, the patient still has symptoms that provide a basis for investigation. When the provider is truly at a loss, the feeling of disequilibrium may stifle his/her ability to proceed. Honesty and humility are the keys to a successful outcome. Portraying omniscience when knowledge is lacking is detrimental to the forging of trust.

When seeing a patient with a presentation for which an immediate diagnosis cannot be made, do not be hesitant to share this information with the patient. Confidence does not need to be lost. Instead it can be portrayed to the patient by the demonstration of commitment to finding the answers. Fulfilling your obligation to the patient may require research, testing, or referral. Reassuring the patient of your intent demonstrates your perseverance. Being willing to say to a patient, "I do not know but let's find out" and pulling a reference text from a bookcase can add a level of mutual respect to the relationship.

CONFIDENTIALITY

The tenets of professionalism dictate that **confidentiality** is inherent to the patient-provider relationship. Not only is the maintenance of confidentiality another key to building trust, it is a legal requirement. The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) was designed to protect the private health information of patients and carries heavy civil and criminal penalties if information is disclosed without the consent of the patient.

Much more common than intentional disclosure of a patient's private information is inadvertent disclosure. Patient information should never be discussed in common areas where other patients, staff, or healthcare workers may overhear these discussions. Though providers may take precautions to avoid using patient names, discussion of the case alone may be enough to result in inadvertent dissemination of confidential information. A patient in a semiprivate room is seen by his surgeon during morning rounds and is told he is scheduled for 10 AM. After the surgeon leaves, the wife of the man in the bed next to him asks why he

was in the hospital. He simply replies that he is having a minor procedure done, preferring not to share his personal information. Still, she is able to learn with some likelihood what the gentleman is having done when, while riding in the elevator, she overhears the same surgeon tell his medical student to read up on penile implants for his/her 10 AM case.

Establishing confidentiality early on in the encounter supports the development of trust and gives patients the opportunity to share more information with their provider than they may otherwise do. Though the majority of encounters will not require this discussion, there may be times to assure the patient directly that any information he/she shares with you will be kept confidential. These times often surround sensitive topics such as sexuality, infectious disease, abuse, dependency, and mental health issues. You should ask patients if there is anyone that they would like you to talk to about their condition. This reassures them that unless they give you permission, you will not share the information with anyone.

There are times when providers are legally required to report information. Some examples of these include when patients state that they intend to harm themselves or others, when there is suspected abuse of a minor or elder in the care of another, or when the diagnosis of HIV is made. Laws covering mandated disclosure vary from state to state, and providers must familiarize themselves with the requirements in the area of their practice. Should providers find themselves in a situation where they are legally required to share information with others, trust can be maintained by being forthcoming as soon as the possibility is identified during the encounter.

Mrs. Gearhart brings her 16-year-old daughter Jennifer in to see you because of persistent headaches. She is concerned because Jennifer, who had previously been a straight-A student, is missing significant amounts of time at school and her grades have dropped to the point where she may need to repeat the year. After initial questioning and a physical exam, you are concerned about the vagueness with which Jennifer answers your questions. You explain to Mrs. Gearhart that Jennifer is becoming a young lady and that this is a chance to develop a relationship and trust with a physician. You ask if you could summarize the history with just her daughter alone, if it is all right with Jennifer, assuring both of them that no physical examination will be performed and an assistant can come into the room if either of them prefers. Mrs. Gearhart consents and leaves the room. The conversation should start with an explanation of why you wished to speak with her alone. Assurances of strict confidentiality, however, cannot be made, as some situations may require you to share the information.

"Jennifer, I'm concerned that these headaches you're having are being caused by something going on in your life. I wanted to speak with you in private because I know as you get older there are some things that you may not feel comfortable sharing with your mother. You are my patient and there are some things that we can talk about that I won't be required to share with your mother unless you ask me to, like alcohol, drugs, or if you've become sexually active. But there are other things that I would be required to share, like if you were being sexually or physically abused, or if you had intentions to hurt yourself or others. In any case, I will do whatever I can to help you. That being said, is there anything you can share with me that can help me figure out where headaches are coming from?"

At this point, the patient has the ability to determine what information she is willing to share. Whether or not she does so, you have not made the mistake of ensuring confidentiality only to later find that you are required to report what you have learned, losing you the trust of your patient.

MEDICAL ETHICS

We have chosen a profession that often places our families second. When the patient walks in at 4:45 on a Friday afternoon, we must strive to provide the same level of care, concern, and commitment that was shown to the first patient on Monday morning.

Medicine as a profession demands stewardship and vigilance in ethical behavior long after the day is completed. Our social networking must protect the profession and its moral code. Confidentiality does not dissolve on the weekends. It is very difficult to gain the trust of our patients and the community when we preach one word but speak another.

Whether it is documentation, billing, or the self-reporting of errors, we are called to the highest levels

Medical ethics: moral principles and rules of conduct in the practice of medicine

Health Literacy: the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions

of morality. All professions are meritorious but when an accountant makes a mistake, amendments can be made. When we make a mistake, we affect the lives and well-being of our patients, their families, and ourselves. Vigilance in upholding **medical ethics** through our moral code can be found in maintaining awareness of our calling and our duty.

PROFESSIONALISM CHECKLIST

- Wear professional attire.
- Maintain good hygiene and grooming.
- Prioritize patient concerns by verbally acknowledging them.
- Demonstrate compassion and kindness.
- Be confident but avoid egotism.
- Assure and preserve confidentiality.
- Adhere to the highest ethical standards.
- Avoid participating in behaviors that you would not want patients to emulate.

Educational and Instructional Skills

The skills required to provide exceptional care to your patient go beyond the ability to make the correct diagnosis. If the patient fails to understand the diagnosis, treatment options, and risks and benefits of each, he/she will have little invested in reaching for successful outcomes. Your ability to involve the patient and gain a commitment from him/her relies heavily on your ability to educate and instruct the patient at appropriate levels.

HEALTH LITERACY

Healthy People 2010 defines **Health Literacy** as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[2] And yet, as reported by the Institute of Medicine in *Health Literacy: A Prescription to End Confusion*, nearly one-half the population in the United States has difficulty understanding and using health information.[3]

Health information is frequently shared with patients in the form of printed materials that require a tenth-grade or higher level of reading comprehension. Contradictory to this practice is the finding that most adults in the United States read at the eighth- or ninth-grade level.[4] Printed instructions or results given or mailed to patients should therefore be written at the sixth-grade level.[5]

Therefore, the art of educating and instructing patients must be based on their ability to:

- Understand the diagnosis they are being presented
- Grant informed consent after considering the identified benefits, risks, and alternatives of each treatment option
- Participate in building a treatment plan based on recognizing treatment options, including that of declining treatment
- Understand and follow verbal and written provider directions, including those on self-care, health maintenance, taking medications, patient-based medical literature, and follow-up instructions
- Articulate objectives, questions, and concerns
- Seek out additional information to aid in decision making
- Make decisions

There are many factors that influence the level at which education and instruction of the patient should occur. Early and advanced age, lower socioeconomic status, learning and cognitive disabilities, experience with chronic medical conditions, and immigrant and minority ethnicity are but a few factors that contribute to vulnerability of patient populations.

AGE OF THE PATIENT

Sharing diagnoses with preadolescent patients should be appropriate to their level of comprehension. For example, after examining a 5-year-old with a low-grade fever, clear runny nose, and sore throat, you might share, "You have a cold" instead of, "You have a viral upper respiratory tract infection." Even downplayed to the level of "You have a virus" is likely beyond their comprehension. The responsibility of adhering to a prescribed treatment plan is delegated completely to

the caregiver from infancy through the toddler stage and drifts consistently toward the patient the closer the patient advances toward adolescence. However, moving the entire responsibility too swiftly toward the caregiver should be avoided. The recently potty-trained, 4-year-old female with recurrent urinary tract infections may be quite capable of understanding the need to wipe from front to back after urinating in order to help prevent infections.

Similarly, when the adolescent patient is seen but ignored while the discussion of the diagnosis and treatment plan is shared with the parent, the provider misses the opportunity to recognize the developing independence of the patient and the chance to build trust while deepening the patient-provider relationship.

Adults with learning deficits or cognitive deficiencies may always require caregiver assistance throughout their lives to ensure success. However, attempts at independence may reveal unsuspected ability to adhere to treatment plans, allowing for greater autonomy for the patient.

Many adult patients will demonstrate comprehension and cognitive abilities that allow one-on-one discussion of the diagnosis and treatment plan solely with the patient. However, it is prudent to ask patients if anyone else should be involved in the discussion. Inclusion of family members, significant others, or even friends at the consent of the patient should be explored. Though many will likely decline the offer, providers may be surprised when the offer to include others is accepted and acted upon.

Cognitive function begins to decline with advanced age and includes the ability to accurately read, interpret, and follow written instructions, patient-based medical literature, and directions on how to take prescriptions. It is important to assess patient understanding at each patient visit. As the encounter is concluding, ask the patient to relate what his/her understanding of the diagnosis is and have the patient recount the steps in the treatment plan. This approach ensures that both the patient and the provider have shared understandings of what is required for the best outcomes.

LOWER SOCIOECONOMIC STATUS

Socioeconomic status typically comprises the level of education attained, occupation, and income, and commonly correlates with the health status of our patients. These three components have direct effects on health care, healthcare choices our patients make, and environmental exposures.[6]

Healthy food choices are aligned with increased costs; therefore choices are restricted for our patients with lower levels of income. It is easy enough to recommend a balanced diet consisting of lean meats, fruits, and vegetables, but our patients may lack the means to acquire them. Still, educating the patient on the avoidance of known offenders such as fast-food burgers and fries is vital.

Lower educational levels are associated with increased rates of smoking. It seems contradictory, then, that those with the lowest levels of education, who have lower levels of income, choose to spend their limited resources on the expense of purchasing cigarettes with the known associated health risks. Patients with lower levels of education also have higher risk factors for the development of cardiovascular disease, including high blood pressure and elevated cholesterol levels.[7] Lower socioeconomic status has also been shown to be associated with low birthweight, arthritis, diabetes, and cancer.[6]

LEVEL OF EDUCATION

Learning disabilities and the attained level of education must be considered when educating and instructing the patient. Recognition of learning disabilities may require the provider to seek further support services available to the patient or to devise alternative instruction methods, such as use of illustrations. The level of education achieved by your patient should be assessed and documented at the first comprehensive visit. At times, providers may overlook details that may seem obvious to themselves but that can be quite confusing for the patient. For example, patients have commented that suppositories are difficult to swallow and birth control pills have a tendency to slip out of the vagina.

When prescribing medications, it is important for the provider to explain exactly how the medication should be taken, including the name of the medication, the amount, frequency, and route. Written instructions on medication labels should be supplemented with handwritten instructions when appropriate.

Culture: a dynamic and creative phenomenon, some aspects of which are shared by large groups of people and other aspects of which are the creation of small groups and individuals resulting from particular life circumstances and histories

Cultural competence: the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring the delivery of care to meet patients' social, cultural, and linguistic needs

When writing for a prescription medication, both brand and generic names should be given. This is evident when the arthritic patient with gastric ulcers is advised to stop taking Motrin, but when seen in the emergency room three days later confirms that she stopped the Motrin and switched to ibuprofen because she needed something for her pain. Motrin and ibuprofen are the same medication.

We cannot expect our patients to remember dosages of each medication they take, though we can encourage them to keep a written list with them at all times. When instructing the patient in dosage, units of administration such as 1 tablet, 1 teaspoon, and 1 puff are appropriate. Frequency should be specific. "One tablet twice a day" does not provide enough specificity. The patient may take the first tablet when awakening at 8 AM and the second at noon with lunch because he/she heard that you should always take medications with food. If the medication is meant to last for 12 hours, the patient will have inadequate drug levels from midnight until 8 AM.

Route of administration should also be provided, as well as any specific instructions related to using the medication. For example: "Mrs. Cook, because your blood pressure has been high for each of your last visits, we are going to start that new medication that we talked about, hydrochlorothiazide. Some people just call it HCTZ. These will be in tablet form with each tablet having 25 mg of the medication. This medication typically makes you urinate more frequently, so you should take one tablet each morning. That way you won't be up all night going to the bathroom. You should link taking it to something you do about the same time every day, like when you first get out of bed, brush your teeth, eat breakfast, or watch the morning news."

ETHNICITY AND CULTURAL COMPETENCE

Primary care clinicians represent the front line in the delivery of effective health care and can play an important role in addressing racial and cultural disparities. The fact that 49.6 million Americans (18.7%) speak a language other than English at home, and 23 million Americans (8.4%) have limited English proficiency, highlights the importance of the need for **cultural competence**.[7,8]

Increasing recognition of well-documented disparities in health status, healthcare access, and healthcare service delivery by race, ethnicity, socioeconomic status, gender, age, sexual orientation, and other sociodemographic characteristics in the United States has resulted in a call for change.[9] One approach to address such disparities suggested by the Unequal Treatment report is to integrate cross-cultural education into the training of current and future health professionals to improve the quality of health care and healthcare communication.[9]

Lack of cultural awareness is believed to be a barrier to improving health care for minority patients, particularly when evidence suggests that patient race has a subtle but important influence on clinical decision making by physicians.[10]

Cultural competency training can provide insights into caring for a diverse patient population by increasing clinician awareness of the need to improve care for patients from diverse backgrounds.[10]

Culture can be defined as a "dynamic and creative phenomenon, some aspects of which are shared by large groups of people and other aspects which are the creation of small groups and individuals resulting from particular life circumstances and histories."[11] It can be viewed as a process that links the past to the present and is shaped in part by social, historical, and political context. Culture shapes lifestyles and beliefs that ultimately impact on one's risk for and subsequent response to health and illness.[11,12]

Unhealthy habits may not be exclusively an individual or personal matter. They are often related to learned social behaviors. People from various cultural orientations view sickness and health differently.[12] As such, culture can affect decisions about choosing healthcare providers, describing symptoms, and considering treatment options.[11]

Culture also influences the choice to obtain medical treatment and to follow treatment recommendations. Although often viewed narrowly, culture is broader than race or ethnicity. It extends to other areas, including language, gender, class, age, sexual

orientation, and religion.[9,11] For example, African American patients report more lower-quality care experiences with physicians than do white patients, and often perceive bias in healthcare delivery.[10] Infant mortality rates are twice as high among African American infants as whites, and Hispanics are less likely to receive smoking cessation messages.[13]

It is believed that socioeconomic status accounts for much of the observed racial disparities in health outcomes. Minorities more often lack health insurance and a primary care physician.[13] Uninsured individuals are less likely to have a regular provider, are more likely to report delaying seeking care, and are more likely to report that they have not received needed care—all resulting in increased avoidable hospitalizations, emergency hospital care, and adverse health outcomes.[13]

Cultural competency in health care is defined as "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring the delivery of care to meet patients' social, cultural and linguistic needs."[14,15]

The underlying motivation for recognizing culture is that culture is intertwined with an individual's health beliefs, values, preferences, and practices.[12] Culturally sensitive care is essential to creating the optimal patient-centered experience; effective patient-provider communication; delivery of high-quality, evidence-based health care; achievement of positive treatment outcomes; and high patient satisfaction rates.[14,15]

Cultural humility "incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations."[16] Culture should be considered a factor (if relevant to the patient) in health care.[15]

The goals of cultural competency training include:

- Understanding attitudes such as mistrust, subconscious bias, and stereotyping that practitioners and/or patients may bring to the clinical encounter
- Attaining knowledge of the existence and magnitude of health disparities, including their multifactorial etiologies and the multiple solutions required to eliminate them
- Acquiring the skills to effectively communicate and negotiate across cultures, including trust-building and the use of key tools to improve cross-cultural communication and relationship building[13]

Several tools have been developed in an effort to facilitate clear communication between patients and physicians. The ***Ask Me 3*** pamphlet takes a simple patient-centered approach to improving health outcomes, by encouraging patients to understand the answers to three simple but essential questions in every healthcare interaction:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?[16]

These questions serve as an activation tool encouraging patient participation in the healthcare visit and decision making while establishing good interpersonal relations and facilitating information exchange.[16] It can aid in the reduction of health disparities. Research has found that patients find the questions to be a useful framework for engaging in conversation with their physicians.[16] Another tool that can be used by practitioners to improve communications is the **4 Cs**.[17] This tool can be used to help patients articulate their preferences and understand the needs of a diverse patient population:

- Call: What do you call your problem?
- Cause: What do you think has caused or contributed to your problem?
- Concern: What concerns you most that we need to be sure to address?
- Cope: What are you currently doing to cope with your problem?

Cultural humility: the lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations

***Ask Me 3*:** tool to facilitate clear communication between patients and physicians that takes a simple patient-centered approach to improving health outcomes by encouraging patients to understand the answers to three questions: (1) What is my main problem? (2) What do I need to do? and (3) Why is it important for me to do this?

4 Cs: tool used to improve communications by helping patients articulate their preferences through the use of four questions: (1) Call: What do you call your problem? (2) Cause: What do you think has caused or contributed to your problem? (3) Concern: What concerns you most that we need to be sure to address? and (4) Cope: What are you currently doing to cope with your problem?

Listening is a simple practice that can enhance the health and well-being of patients in a number of ways:

1. It is a mechanism for ascertaining details of a patient's concerns, attitudes, circumstances, and belief system that are essential to appropriate treatment.
2. Patients who experience listening may develop a higher level of trust with their caregivers.
3. Patient compliance and outcomes may improve.
4. New solutions may be discovered.[18]

Enhanced active listening skills such as nodding when talking to another person, asking clarifying questions, paraphrasing another person's statements, using of proper posture and eye contact, paying attention, and refraining from judging the patient can enhance patient communications.[18]

Learning about each patient's experience and culture, and empowering him/her to ask questions, will improve the patient's healthcare experience.[18] Human interactions should be rooted in recognition of the innate equality, dignity, and worth of every person.[18] Providers should honor the integrity and authority of each individual and support their patient's right to decide what treatment option will best serve his/her needs.[18]

There is value in learning to pay attention, to listen to what is not being said (or to what is being said but minimized), and to learn the art of "waiting" and "asking the right questions" rather than having the right answers.[18] The practitioner should make inquiries that elicit information, clarify ideas, and encourage involvement in healthcare decision making.[18]

Betty Cheng, LCSW, chief operating officer at the Charles B. Wang Community Health Center in New York, stated, "I know I have no way of being able to understand everyone's cultures, so the key is to listen to each patient and let them teach you about their culture."[18]

Healthcare providers should develop practical skills such as listening and relationship building that can be applied to all cultures, while learning the values, attitudes, behaviors, and spiritual beliefs of those multiethnic patients whom they serve.[19]

Things to consider include hiring trained, full-time interpreters, educating language-competent staff members in interpretation techniques, and accurately tracking patients requiring language assistance.[14]

It is recommended that services be customized to meet the unique needs of specific populations to whom you will be providing health care. This will result in reduced barriers to care. Health disparities can be addressed through staff education, physical environment redesigns (including the use of universal symbol signage), and interest in patients' religious practices, opinions about healthcare institutions, and death and dying rituals across the different cultural groups that you will serve.[14] If you can, learn a few words from your patient's native language. Speaking the same language as the patient automatically makes the patient feel more at home.[8]

Ask employees from the appropriate backgrounds to teach one another important cultural concepts, such as whether you shake hands or nod your head as a greeting, what questions you can ask in front of other family members, how much eye contact to make, and how close to stand. Contact the language or other appropriate department of a local college or university to find someone who is familiar with the culture, behavior, and beliefs of the ethnic groups for whom you provide medical care. Develop cultural fact sheets and diversity workshops for your practice.[8]

Browning and Waite advise that "patients are the experts on themselves. We will never know more about people or their culture than they do. They have to tell us who they are, and we need to listen to what they want."[18]

Providing patient-centered care is one approach to improving communication and reducing health disparities.[17] Evolving one's education and practice to achieve true cultural competency requires a lifelong process of learning and reflection.[12] Online training resources include the following:

http://culturalmeded.stanford.edu/
http://www.nhlbi.nih.gov/training/
http://culturalmeded.stanford.edu/teaching/unnaturalcausesresource.html
https://implicit.harvard.edu/implicit/

PROVIDING THE DIAGNOSIS AND BUILDING THE TREATMENT PLAN

When patient outcomes are poor, it is convenient for providers to call patient compliance into question. The

last prescription you wrote for a cholesterol-lowering medication was a 30-day supply that should have lasted the patient only until his follow-up appointment. He returns to your office three months later having missed the earlier appointment, without improvement in his cholesterol level or having called in for a refill. In this case, doubting compliance would be justified. How tempting to confront the patient by saying, "No wonder your cholesterol hasn't improved. You ran out of medication two months ago!" Before you do so, perhaps you should ask yourself what factors may have contributed to lack of compliance. Did the patient experience an adverse side effect? If so, did you instruct the patient on which side effects to expect and what to do if they did occur? Was the patient unable to afford the medication? Did a family crisis prevent him from returning earlier? Did you properly educate the patient on the importance of the medication?

The building of a treatment plan is a cooperative effort between the patient and the provider. Though patients seek the guidance, knowledge, and experience of the provider, it is important to avoid dictating a course of action without input from the patient. Patients who are asked to contribute to their own health care are invested to a deeper degree and demonstrate increased compliance. This process begins with sharing the diagnosis with the patient.

The majority of diagnoses are accurately obtained through detailed and concise history taking. Physical examination functions to confirm the diagnosis and may lead to other diagnoses that were unsuspected, such as finding a heart murmur in a patient who denies ever having one. At other times, the diagnosis is elusive and requires further investigation. In such cases the provider constructs a list of the possible diagnoses, called the differential diagnosis. Recognizing early in your medical career that we as providers do not always know the diagnosis allows you to approach the patient with honesty and sincerity when discussing your suspicions.

It is always important to provide your patient with a proposed diagnosis, even if you are not sure of what the exact diagnosis is. For example, a patient presents with a chronic cough. After taking a thorough history and performing a physical examination, you suspect gastrointestinal reflux disease (GERD) as the primary cause. However, the social history reveals that the patient has smoked for 20 years, having successfully stopped two years prior. In your differential you suspect GERD as the most likely diagnosis, but you also consider chronic obstructive pulmonary disease (COPD) and even lung cancer as other possibilities.

Sharing this information with your patient requires educational skill. Skill in educating your patient requires that you share your suspicions with her and yet avoid causing stress or anxiety.

Though the following would seem intuitively inappropriate, there would be few providers who could deny observing similar conversations:

- "Mrs. Smith, I think your cough is coming from acid reflux although your history of smoking bothers me. You could have chronic lung changes from all of that smoking you did, even lung cancer. Might not be but I'll check it out."

Though a diagnosis was proposed, no skill in its presentation was apparent. It lacked both empathy and concern for the anxiety it may have induced in the patient. The tone is accusatory, immediately putting the patient on the defensive instead of drawing her in as a collaborator in her own health care. The same information can be shared with the patient in a completely different, nonconfrontational, empathetic way:

- "Mrs. Smith, coughing such as you describe very frequently comes from acid reflux. There are some other possibilities that I am thinking about. I'm very impressed that you stopped smoking two years ago. You did the best thing you could have done for yourself. There could have been some injury to your lungs from the smoking, so we'll need to check that out. I would recommend a test that measures how well you breathe and an x-ray of your chest. How do you feel about that?"

Here you shared the diagnosis that you felt was most likely, but openly expressed that there were other possibilities that must be explored. Instead of criticizing the patient for her smoking and blaming her for the condition she was in, you provided encouragement and positive reinforcement for her successful smoking cessation and bolstered her self-esteem. Part of your evaluation included testing to rule out the other diagnoses. You did not simply dictate that these tests

needed to be done; you explained why they should be. Saying, "We'll need to check that out" includes the patient as part of "we," the investigating team. "Need" implies the necessity of the action. Finally, though you built the differential diagnosis through your knowledge of medicine and recommended the appropriate evaluation, you also asked the patient for her input and gave her the opportunity to ask questions, seek clarification, or even object to the proposal.

It is important to clearly explain the diagnosis. The practitioner must determine the level of detail to present. Examining the pathophysiology from the previous example of GERD, we see the movement of gastric fluids in a retrograde fashion from the stomach into the esophagus. This is usually prevented from occurring by a lower esophageal sphincter that constricts, and is aided by the anatomical design of the gastroesophogeal (GE) junction with abnormalities such as that associated with a hiatal hernia allowing reflux to occur.

Providing this level of information to the patient would rarely be warranted unless the patient is knowledgeable in the practice of medicine. Instead the discussion might go as follows: "We have acid in our stomachs that helps to break down foods and kill bacteria. That acid is supposed to stay in the stomach but sometimes goes back up into the esophagus. If that happens repeatedly, it can cause injury, which might be felt as 'heartburn.' Our goal in treatment is to prevent the injury from happening." This would provide the diagnosis in a short, simple format using terminology the patient can understand.

Building a plan of treatment involves our clinical expertise but must involve the patient in the treatment decision making. A patient needs a medication for high cholesterol but has not tried dieting and exercise, which may be recommended as the first line of treatment. Ask the patient which route he would like to take. You may discover that the patient would rather start the medication now, since he knows he will be noncompliant in restricting his diet and exercising because his occupation requires long days at work and eating on the road. Conversely, a second patient "hates to take medication" and would much rather make an honest effort at balancing his diet and beginning an exercise program. In either case you have involved the patient in his treatment plan, which means he is more likely to feel invested in his path to success, as he now "owns" it.

Treatment plans must be easy to understand and logical. This may require writing the information down for the patient. Following your description of the diagnosis of reflux, you explain the options for the plan of treatment. First is a discussion on behavioral aspects that allow stomach acid to slide back up into the esophagus, such as use of tobacco and alcohol, and eating before lying down. Avoidance of these things alone reduces reflux.

Next you may discuss the different types of medication that are used for the condition. "Mrs. Smith, there are several classes of medications that we can use to treat reflux. We often use a stepwise approach, trying milder medications first and then advancing if symptoms fail to improve. Some of these medications are over-the-counter, and some require a prescription. Do you have any thoughts or concerns about this?" Giving the patient the opportunity to express concerns and options again encourages adherence to the treatment plan and ultimately an investment in the outcome, as the patient was instrumental in its formation.

Mrs. Smith advises you that her finances are fairly tight at the moment and that she would prefer the least costly alternative as her insurance does not cover prescription medications. You may now discuss the options found among the various over-the-counter medications, which, when combined with the changes in behavior, have proven efficient in the treatment of reflux.

Consideration for including others in the development of a treatment plan should be tailored to the individual patient. A 24-year-old male with a wart would not likely prompt the provider to inquire if the patient would like anyone else involved in the decision making. The opposite is true when a very independent 86-year-old man is suffering from vertigo. His restrictions on driving and his high risk of falling necessitate the development of a treatment plan that includes an assessment of the types of support the patient has through family and friends. Though he may be hesitant at the consideration of loss of some of his independence, reassurance that support is necessary while he works at recovering his balance and will likely

speed his recovery and return to independence will ease the transition.

Summarize the visit by asking the patient to restate the plan of treatment. This assures that the plan was presented logically and that the patient fully understands it.

EDUCATIONAL AND INSTRUCTIONAL SKILLS CHECKLIST

- Use the principles of Health Literacy when educating and instructing patients.
- Recognize disparities in medical outcomes presented by low socioeconomic status.
- Identify ethnic populations within your practice setting and explore related cultural beliefs and preferences concerning health care.
- Clearly explain diagnoses, avoiding medical terminology.
- Invest the patient in the outcome by including the patient in the development of his/her plan of treatment.
- Inquire if others should be included in developing a plan of treatment.
- Assure that the treatment plan is logical and easily understood.
- Have the patient restate the treatment plan to assure understanding.

Interviewing a patient is an art that goes far beyond simply asking historical questions surrounding a medical complaint. The encounter begins with the provider's mindset and mindfulness in avoiding prejudice. Adherence to the Humanistic Domain requires expertise in verbal, listening, and educational/instructional skills, while displaying empathy, respect, and professionalism. Patient encounters must account for diversity of cultures and Health Literacy.

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