Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

The Patient Encounter and Patient Satisfaction, Part II

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Introduction

As described in Part I (*DC* Sept. 1, 2002 www.chiroweb.com/archives/20/18/01.html), if one hopes to provide successful patient care, it is essential that one develops effective interpersonal skills. In practice, success in the art of patient management begins with designing the layout of one's office or clinic in a way that, in effect, says that the doctor is here for you and wants you to feel comfortable, with minimal stress and anxiety. Body language was also addressed, since the interaction of doctor and patient flows along multiple channels simultaneously, complementing language with the subliminal cues of posture; movement; proximity; gaze; touch; and attire. I continue with how one uses language, and how cultural differences need to be taken into account.

Conversational Style

How the spoken word is used constitutes the single strongest predictor of outcome for creating trust and responsiveness.[20,3,14,4,5] Language usage is also the most difficult skill to acquire, not least because the physician is caught in a dialogic trap. Time constraints in the practice require that history taking and other dialogue be accomplished rapidly and efficiently.[17] One skill still taught in clinical training is how to keep a conversation on track. Cut off digressions as gently as you can.

Encourage short answers. Keep the focus as much as possible on clinically relevant symptoms and experiences. Get it all done in five minutes (or eight - or 12 - or whatever time demands). The physician who is skilled in eliciting information rapidly can be remarkably efficient in coming to a diagnostic conclusion.

But hold on a moment! Your goal on intake is much more demanding than only to complete a differential, as important as that certainly is. Your goal is to succeed in a highly complex enterprise that ultimately results in patient satisfaction. The physician's dilemma is that those language practices essential to moving expeditiously through an intake interview are precisely those ways of conversing that can result in dire - at least, sometimes dire - consequences for the physician-patient relationship, and for patient morale, compliance and outcome.

The questions and answers that dominate an intake conversation can be experienced on a subconscious level as gestures of dominance, as power moves in the clinical encounter, because they include certain topics (those important for the physician) and exclude others (those important for the patient). In this starkly asymmetrical exchange initiated, controlled, modulated, and terminated by the doctor, a patient can end up feeling psychologically weakened and emotionally drained.[6,7] The most emotionally harmful gambit and the clearest example of psychological power moves is the practice of interrupting - stopping the patient abruptly to get the exchange back on track, which is experienced as dismissing what the patient wanted to say as irrelevant and unimportant.

Patients do not usually interrupt doctors, but doctors often interrupt patients. The benefit to the doctor is efficiency, but the cost is to produce an unhappy, resistant, deflated patient. Asymmetrical interruption, a semiotic process that operates for the most part beneath the level of discursive awareness, is the key linguistic cause of pervasive dissatisfaction with clinical encounters in the U.S. today.

According to anthropologist James Wilce, the way the diagnostic process is managed can result in a loss of self-esteem, or a loss of face on the part of the patient, " a form of medical domination that has no clear therapeutic value."[21] Howard Waitzkin, a physician, recommends that "doctors should let patients tell their stories, with many fewer interruptions, cut-offs, or returns to the technical." Especially in the first encounter, they should be allowed, Waitzkin urges, to present their narratives in an open-ended way that permits a more active role in questioning, challenging, and directing the flow of conversation. "When patients refer to personal troubles that derive from contextual issues, doctors should try not to marginalize these connections by reverting to a reified, technical track."[19] In a similar vein, Elliot Mishler urges practitioners not to exclude the "voice of the life world" on the assumption that patient success will derive from exclusive attention to "the voice of medicine."[15]

Wilce, Waitzkin, Mishler and others in agreement with them are obviously right. The domineering conversational style of an intake interview comes with a high psychological cost for many patients. However, what these authors have not explained is how a busy physician can accomplish all that needs to be done in a day's work and still allow for a more time-consuming, patient-responsive intake interview. I don't know the answer. Communication in clinical settings has not been subject to sufficient investigation to permit systematic theorizing, which leaves us where we were, dependent on the art of practice. Perhaps one can learn to be more sensitive to the subtle clues of facial expression and voice tone that may highlight occasional patients who find it difficult to cope with the discourse of power, so that they can be given more time, while others who appear undisturbed by it can continue to be handled more expeditiously. With that kind of awareness, perhaps one can manage to schedule in enough flex-time to somehow serve the needs of all. The only true solution, of course, would be to change the whole political-economic system, health care included, to be more person oriented. Waitzkin finds many who agree with him that, "especially in the United States, the entire health care system cries out for reform."[19]

Confounding Variables

No one communicative style is going to succeed in contemporary American practice because of the cultural and individual diversity of our patients.[11] You need to be sensitive to ethnic, racial, class, and gender differences that can impact mightily on how people respond to your care. In expressing concern over noncompliance, for example, you need to be aware of realities in the life worlds of patients from different backgrounds. For example, Ferdinand says of some of his minority patients: "Here is my appeal to you. Try to imagine yourself in your patients' shoes. The angst in their daily lives can make taking their medicine number five on their list of top-five priorities." And, he adds, what does your reprimand do to that noncompliant patient? "Now that person has one more confirmation that he or she is worthless, hopeless, and no good."[8] Where is the therapeutic benefit in that?

A doctor may perceive some Native Americans as depressed and unresponsive in the clinical encounter. Some have been prescribed antidepressant medications based on a clinical impression that was not ethnographically informed. A Native American concept of politeness requires that one

show little or no emotion; that one not interrupt or respond too quickly; that one speak softly; that silence is valued.

This manner of politeness is not pathological, it is cultural.

"Most Americans are uncomfortable with silences and tend to fill them with words, making small talk," says Geri-Ann Galanti, recalling her anthropological studies in hospital settings. "The Navaho use silence to formulate their thoughts. Words should have significance." That's why you may ask questions and seem to get no response.

You have to learn to get comfortable with long pauses if you are talking with someone from that kind of a tradition.[9] Getting informed consent can run into cultural barriers. In some societies it is felt that the signed consent should come from the family head rather than from the patient, even though the patient is not a minor. For some patients, there can be outright confusion about the intent of the law. Galanti reports on a 65-year-old Middle Eastern man who resisted signing a consent form for his planned heart catheterization. "Why was he so reluctant to sign? From a cultural perspective it may be because many Arabs believe that since the doctor is the one with the knowledge and training, the doctor should be the one to make the decision."[9] Similar reactions are reported for immigrants from other parts of the world, as well as for many American-born patients whose bad experiences with contractual law make them fearful of signing any legal document.

Differing concepts of time can greatly impede clinical encounters, as in the case of a Mexican-American woman told to present herself at "lunchtime" for a meeting with a nurse. She was an hour late because lunchtime for her meant between one and two p.m. The result was an encounter between a sullen, irritable nurse and a misunderstood patient who was unaware she had caused a problem.[9]

In the West, one may encounter medically misleading folk ideas from different parts of the world relating to how the body functions. Cecil Helman, a physician and anthropologist, describes how doctors and patients may not realize that their conceptions of physiology are very different, even though they use the same lay terms. For example, "blood" in folk belief is often implicated in folk theories about illness in physiologically anomalous ways, as when illness is thought to result from too much volume ("high blood," which is often confused with high blood pressure); too little consistency ("thin blood" as a cause of anemia); poor quality of the blood (in the idea that "impurities" seep into the blood from constipation); or the polluting power of blood (with the idea that contact with menstrual blood can make men weak).[12]

In sum, you need to be your own anthropologist if you are drawing patients consistently from one or another ethnic group.[18,1] Read about their health-related beliefs, and more generally, about medical anthropology. Talk with well-acculturated members of the community about their perceptions of communication difficulties. Employ bicultural or bilingual staff to make your office more effective. Above all, become as sensitive as you can to the nuances of meaning inherent in every act and vocality of your professional work.

Quality Control

Faced with increasing competition, and demands from payers and accrediting entities that medical establishments demonstrate the value of their services, hospitals and other health care organizations are now putting in place a philosophy of total quality management as an overall organizational objective.[10,13,16,2] Institutionalizing total quality control does not guarantee success.

Overall performance is multifaceted, and errors will occur in spite of massive administrative efforts. However, the most costly errors are sometimes made in the least technological and most ordinary areas of human behavior. Attention to the intake interview; office setting; body language; semantics of conversations; and the complications of cultural diversity offer low-tech opportunities to meet basic demands of quality control. These ensure that whatever else may go wrong, good relations between patients and professional personnel will be there to facilitate healing, and increase the likelihood that those you care for will be satisfied with what you have done for them.

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