



ICPCM Newsletter - December 2014

The Heart and Art of Medicine

Jim Appleyard

President, International College of Person Centered Medicine

The clinical consultation between a person and a physician is at the heart of medical practice. It is a dialogue between two individuals. (1) A conversation between a person seeking help as a patient with a physician who has additional medical knowledge and skills. The patient/ physician relationship is founded on service - the service provided by the physician to their patient within a professional code of ethics which is enshrined within the World medical Associations International Code of Medical Ethics 1949 et seq. It is the relationship built on trust within which two-way communication is key.

Trust can only be assured if patients believe that the physician respects them as individuals, will act only in their best interests, avoid 'harms' where possible, be truthful and be treated equally with others according to their need.

The physician also has a duty of care to their patients and should keep their medical records secret within applicable national laws.

These ethical principles need to become 'internalized' as the professional conscience, to act as a compass through the complex scientific medical psychological social, cultural and spiritual scene.

These principles relate both to the individual health care professional as a basis for the 'trust' given by the patient and to society in general where they form part of the essential 'contract' between the health care professions and society allowing the physician to work as an independent clinician whose primary duty is to their patient. Only in this 'trusting' culture will a 'patient's inner worries and secrets be gradually shared with their physician.

As the cost of health care has escalated additional pressures on this 'professional' space by Healthcare providers, Insurance Companies and Governments are occurring which are distorting the patient/physician discourse.

During the clinical consultation, eliciting a 'history' from a patient is one of the least perfected and most neglected clinical skills despite a wealth of research and time spent in undergraduate training (2). Yet for the great majority of "patients' the narrative history is the most important and most revealing part of any personal health data . Too often a computer-generated form is completed with the minimum of narrative followed by a cursory clinical examination and a huge array of expensive investigations from which a diagnosis is expected to emerge. It is important to realize that not only is the patient presenting with symptoms of a possible illness but experiencing the effect of all of their life's events in their biological, social, psychological cultural and spiritual dimensions

Those starting out on a medical career may need a format to act as guidance. The person centered Integrated Diagnostic model is being developed and refined to meet this need. It proposes the whole person in context as the Centre and goal of clinical care and public health (3). This encourages a more flexible and conversational style of communication in health care.

It is only through this open interactive conversation style and questioning the physician sorts, extracts, subtracts and adds information into a meaningful format. As rapport is established, elements of the patient's temperament and personality become more apparent and the patients reaction to each question can be noted.

Very often the physician will have a very good idea of the likely diagnosis of the patient's problem within the first two minutes through his or her experienced pattern recognition of the common disease processes. The physician will search for additional clues –information that will aid in the solution of the person's problem. There is then a tendency to move to gather more specific information to exclude other possibilities and confirm the presumptive diagnosis. The danger is that at this stage other pertinent information may not be given by the patient or sought by the physician. Some physicians may avoid eliciting multiple concerns due to the fear of extending the encounter when time is limited.

However, unexpressed patient concerns may lead to a prolonged investigation of a concern hypothesized to be the "chief complaint," but which in reality was the second most important problem. Multiple solicitations early in the visit may enhance the efficiency of the interview by decreasing late-arising concerns, allowing the physician and patient to prioritize problems at the outset to make the best use of their time and minimize implicit assumptions of what the patient wants to discuss. Patients may defer emotionally laden topics until the trustworthiness of the physician is better known or until the physician brings up the topic (4).

The tendency of even experienced family physicians not to seek the patient's complete agenda is similar to the finding of Beckman and Frankel 15 years ago. Despite concern that a patient-centered approach will take more time, the study further reinforces that soliciting all of the patient's concerns does not decrease efficiency. Using a simple opening empathic solicitation, such as "What concerns do you have?," then asking "Anything else?" repeatedly until a complete agenda has been identified appears to take 6 seconds longer than interviews in which the patient's agenda is interrupted (5). Agenda setting is a teachable and learnable skill that deserves emphasis and reinforcement.

A few verbal affective remarks can be effective in gathering clinically relevant information and this is not necessarily time consuming (5). In one study it took only 38 seconds to make a difference! The affective statements that caused this reduction were related to emphasizing being there for the person – the sense of a physician's duty of care - providing reassurance of continuing medical support. These points have been defined as fundamental for effective patient-physician communication. Whilst one of the most difficult tasks for physicians is to convey bad news, physicians who are emotionally supportive can influence patients' emotional functioning and information recall with little effort and time (6).

Affective communication may have the power to elicit beneficial effects in

clinical encounters as it enables patients to adjust better to the emotional and cognitive impact of medical information (7). Indirect effects might also be present. When patients remember more about treatment procedures and their consequences, this may affect adherence to treatment or medication regimen. A few affective statements can have a large impact on patients' anxiety, uncertainty and recall. Affective communication allows physicians to temper patients' emotional responses and improve their ability to remember medical information (6).

We will be exploring these issues further during the Eighth Geneva Conference on Person-Centered Medicine, April 26-29, 2015 in Geneva, Switzerland under the theme *Person-Centered Primary Health Care*. Your own insights will contribute to improving our service to patients, so do come and join our discussions and participate in this important meeting that might influence personal practice and policy makers.

References

1. Mezzich JE. Building Person Centered medicine through dialogue and partnerships International Journal of Person Centered Medicine 2011; 1: 10-13
2. Cutler P (1998). From data to diagnosis 3rd Edition Lippincott Williams and Wilkins
3. Salloum I M, Mezzich JE. Conceptual appraisal of the person centered Integrative Diagnostic Model. International Journal of Person Centered Medicine 2011; 1: 39-42
4. Epstein RM, Morse DS, Frankel RM, Frarey L, Anderson K, Beckman HB. (1998) Awkward moments in patient-physician communication about HIV risk. Ann Intern Med 1998; 128: 435-442.
5. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda. Have we improved? JAMA 1999; 281: 283-287
6. van Osch M, Sep M, van Vliet LM, van Dulmen S, Bensing JM. Reducing patients' anxiety and uncertainty, and improving recall in bad news consultations. The impact of affective communication. Health Psychol 2014; 33: 1382-1390
7. Street RLJ, Makoul G, Neeraj KA, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. Patient Educ Couns 2009; 74: 295-301