BUILDING THE RELATIONSHIP

INTRODUCTION

Building the relationship is a task that is easily taken for granted or forgotten. The sequential components of the interview often dominate as we move through the consultation trying to make sense of the patient's illness and disease. Yet without paying specific attention to the skills of relationship building, these more 'concrete' tasks become much more difficult to achieve. Relationship building enables the patient to tell their story and explain their own concerns, it promotes adherence and prevents misunderstanding and conflict. Building the relationship runs in parallel to the sequential tasks and acts as the cement that binds the consultation together.

Patients wish their doctors to be competent and knowledgeable but they also need to be able to relate to their doctor, to feel understood and to be supported through adversity. Attention to relationship building offers the potential prize of patients who are more satisfied with their doctors and doctors who feel less frustrated and more satisfied in their work.. The objectives that we seek to accomplish in building the relationship with the patient can be summarised as:

- developing rapport to enable the patient to feel understood, valued and supported
- establishing trust between doctor and patient
- encouraging an environment that maximises accurate and efficient initiation, information gathering and explanation and planning
- developing and maintaining a continuing relationship over time
- involving the patient so that he understands and is comfortable with participating fully in the process of the consultation
- reducing potential conflict between student and patient
- increasing both the student's and the patients' satisfaction with the consultation

To help you achieve these objectives, pay attention to each of the following skills:

Using appropriate nonverbal communication

- **Demonstrating appropriate non–verbal behaviour**
  - eye contact, facial expression
  - posture, position & movement
  - vocal cues e.g. rate, volume, intonation
- If reading, writing **notes** or using computer, do in a manner that does not interfere with dialogue or rapport
- Pick up patient's non–verbal **cues** (body language, speech, facial expression, affect); check them out and acknowledges as appropriate

Developing rapport

- **Accept** legitimacy of patient's views and feelings; is not judgmental
- Use **empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly acknowledge the patient's views and feelings

- **Provide support:** express concern, understanding, willingness to help; acknowledge coping efforts and appropriate self care; offer partnership
- Deal **sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

- **Share your thinking** with the patient to encourage the patient's involvement (e.g. "What I'm thinking now is.....")
- Explain **rationale** for questions or parts of physical examination that could appear to be non-sequiturs
- During **physical examination**, explain process, ask permission

USING APPROPRIATE NONVERBAL COMMUNICATION

You cannot over-estimate the importance of your nonverbal communication throughout the medical interview. You need to pay as much attention to the effect of your nonverbal interaction with patients as we do to the impact of your words. You need to recognise patients' nonverbal cues in their speech patterns, facial expression, affect and body posture. But you also need to be aware of your own nonverbal behaviour, how your use of eye contact, body position and posture, movement, facial expression and use of voice can all influence the success of the consultation.

WHAT DO WE MEAN BY NONVERBAL COMMUNICATION?

- **Posture:**

sitting, standing, erect, relaxed

- **Proximity:**

use of space, physical distance between and positioning of communicators

- **Touch:**

handshake, pat, physical contact during physical examination

- **Body movements:**

hand and arm gestures, fidgeting, nodding, foot and leg movements

- **Facial expression:**

raised eyebrows, frown, smiles, crying

- **Eye behaviour:**

eye contact, gaze, stares

- **Vocal cues:**

pitch, rate, volume, rhythm, silence, pause, intonation, speech errors

- **Use of time**

early, late, on time, overtime, rushed, slow to respond.

- **Physical presence**

race, gender, body shape, clothing, grooming

- **Environmental cues**

location, furniture placement, lighting, temperature, colour

WHAT IS THE DIFFERENCE BETWEEN VERBAL AND NONVERBAL COMMUNICATION

- Verbal communication is discrete with clear endpoints - we know when the message has come to an end. In contrast, nonverbal communication is continuous - it goes on for as long as the communicators are in each other's presence. We cannot stop communicating nonverbally.
- Verbal communication occurs in a single mode whereas nonverbal communication can occur in several modes at once. We can send and receive all the nonverbal cues listed above simultaneously; all of our senses can be receiving signals at once.
- Verbal communication is mostly under voluntary control whereas nonverbal communication operates at the edge of or beyond our conscious awareness. Nonverbal communication can be amenable to deliberate control: for instance we use nonverbal cues from voice, body, head and eye movement deliberately to help to co-ordinate the taking of turns in conversation. However, nonverbal communication also operates at a less conscious level. Our nonverbal communication may be "leaking" spontaneous clues to the receiver that we are not even aware of and may be providing a better representation of our true feelings than our more considered verbal comments:
- Verbal messages are more effective in communicating discrete pieces of information and in conveying our intellectual ideas and thoughts. In contrast, nonverbal communication is the channel most responsible for communicating our attitudes, emotions and affect, for conveying the way we present ourselves and how we relate. Considerably more information about liking, responsiveness and dominance is provided by non-verbal than verbal means.

WHY UNDERSTANDING NONVERBAL COMMUNICATION CAN MAKE A DIFFERENCE IN THE CONSULTATION.

Nonverbal communication can work to accent, qualify, regulate, take the place of or contradict verbal communication. In most circumstances, verbal and non-verbal communication work together to reinforce one another. Nonverbal cues enable verbal messages to be delivered more accurately and efficiently by strengthening the verbal message. For example, after you have summarised and asked "Have I got that right?" the patient says "Yes, that's spot on" and smiles, leans forward and uses an animated voice..

When you are deprived of accompanying nonverbal confirmation, your verbal conversation is more liable to misunderstanding: we have all encountered problems communicating over the telephone where denied so many nonverbal cues.

You can intentionally use nonverbal communication to reduce uncertainty and misunderstanding in your verbal communication. "Are you happy with that plan?" accompanied by eye contact, hands opened out and an enquiring facial expression will

indicate your genuine interest. Alternatively, the same phrase accompanied by a closure of the notes, hands banged on the table and a quick look at the patient and then away all suggests that you don't want to know if the answer is no.

As we can see from the last example, the two channels can also work to contradict each other. When the two are inconsistent or contradictory, non-verbal messages tend to override verbal messages. If your verbal statement is "Tell me about your problem" while your nonverbal cues are speaking quickly and looking agitated, the patient will make the correct interpretation that time is at a premium today. If the doctor says there is nothing to worry about but hesitates in her speech as she delivers this verbal message, the patient will assume that perhaps there is some concern and that information is being withheld.

People tend to mirror or imitate each other's nonverbal behaviour - to move or talk in synchronisation - as a gesture of affiliation. You can use this to advantage first by anticipating a positive experience and second, by modelling relaxed attentive listening skills. Unconscious mirroring and reinforcement of this behaviour by patients will enable them also to relax and become more attentive. You can affect others positively through your behaviour.

WHAT THEN ARE THE LESSONS?

You therefore need to be aware of both your patients' and your own nonverbal behaviour.

Reading the nonverbal cues of patients

Being able to "decode" nonverbal cues is essential if you wish to understand your patients' feelings. The cultural norms of the health-care setting mitigate against patients' expressing their feelings verbally - patients are reluctant to express their thoughts or feelings openly but instead use indirect or tacit messages. Nonverbal cues may therefore be one of the few indicators of a patient's desire to contribute their own concerns about a problem.

However, just because spontaneous clues representing true feelings are being sent doesn't mean that you can interpret those cues accurately simply by noticing them - there are many sources of possible distortion and misunderstanding inherent in receiving nonverbal messages. To ensure accurate interpretation of such nonverbal behaviour, it is important not only to observe carefully but also to verify your perceptions verbally. Your interpretations and assumptions may or may not be right: they need to be checked out with the patient.

Picking up on nonverbal cues not only helps the doctor to understand the emotional impact of the patient's illness but is also of considerable diagnostic importance in its own right. Reading the nonverbal cues of depression is an essential part of diagnosing the illness itself, while emotional problems only hinted at through nonverbal channels are often the root cause of physical symptoms.

Transmitting your own non-verbal cues

Similarly, without attention to your own nonverbal communication skills and the messages that you are transmitting through the nonverbal channel ("encoding"), much of your other efforts to communicate may be undone. If your verbal and nonverbal signals are contradictory, at the very least you risk confusion or misinterpretation, at worst your nonverbal message will win out. Nonverbal skills signalled through eye-contact, posture, position, movement, facial expression, timing and voice can assist in demonstrating attentiveness to the patient and facilitate the formation of a helping relationship; ineffective attending behaviour in contrast closes off the interaction and prohibits relationship building.

USE OF NOTES AND COMPUTERS

One of the most important of all nonverbal skills is eye contact. Eye-contact allows the patient to infer that you are prepared to listen. In the absence of eye-contact, the patient will make nonverbal efforts to encourage you to realign your gaze and there is often a reduction in quality and quantity of information provided by the patient. Using records while the patient is speaking is therefore not an efficient way to conduct the consultation. The patient will give their information more slowly and less completely and you may well not "hear" the information provided. Instead consider:

- deliberately postponing using the records until the patient has completed their opening statement
- waiting for opportune moments before looking at the notes
- separating listening from note reading by signposting both your intention to look at the records and when you have finished, so that the patient understands the process

Increasingly, doctors are using computers during the consultation as an adjunct to handwritten records and in many situations computers have replaced written notes entirely. Even more care with regard to eye-contact and body-positioning needs to be taken to consult effectively while using a computer

DEVELOPING RAPPORT

ACCEPTANCE

Earlier, we looked at the importance of understanding the patient's perspective. We examined the need to elicit patients' *thoughts* (their ideas, concerns and expectations) and take note of their *feelings*. But having discovered these thoughts and feelings, what should be your first response?

The accepting response

The accepting response provides a practical and specific way of:

- accepting non-judgmentally what the patient says
- acknowledging the legitimacy of the patient to hold their own views and feelings
- valuing the patient's contributions

The accepting response acknowledges and accepts both the patient and the patient's emotions or thoughts wherever and whatever they are. Note that acceptance here does not mean that you necessarily agree with the patient but rather that you hear and acknowledge the patient's emotion or point of view. This approach is effective in relationship building because it establishes common ground between doctor and patient through a shared understanding of the patient's perspective. Acceptance is at the root of trust and trust is the bedrock of successful relationships**.**

Accepting patients' ideas and emotions without initial judgement may not be easy - especially if they do not accord with your own perceptions. But by acknowledging and valuing the patient's point of view rather than countering immediately with your own ideas, you can support your patients and enhance your relationship. The key concept here is acknowledging the patient's rights to hold their own views and feelings. It helps for patients to understand that it is not only reasonable for them to have thoughts and emotions about their illnesses but it is also important to you for these to be expressed so that you can be aware of and appreciate the patient's perspective and needs.

Functions of the accepting response

The accepting response has three valuable functions:

1. to respond supportively to the patient's expression of feelings or thoughts
2. to act as a facilitative response to obtain a better understanding of these thoughts and feelings
3. to value the patient and their ideas even when their feelings or concerns seem unjustified or perhaps even wrong.

Skills of the accepting response

The following set of skills can be used in the sequence shown below to signal acceptance to the patient. In this example, the patient has expressed his thoughts by saying "I think I might have cancer doctor; I've been getting an awful lot of wind lately":

- **acknowledging the patient's thought or feeling by naming, restating or summarising**

"So, you're worried that the wind might be caused by cancer"

- **acknowledging the patient's right to feel or think as he does by using legitimising comments**

"I can understand that you would want to get that checked out"

- **coming to a "full stop"; using attentive silence and appropriate nonverbal behaviour to make space for the patient to say more**

"Yes, doctor, you see my mother died of bowel cancer when she was 40 and I remember she had a lot of wind - I'm terrified of getting it too"

- **avoiding the tendency to counter with "yes but..."**

Although not a necessary part of every accepting response, it can also be helpful to:

- **acknowledge the value to you of the patient expressing their views**:

"Thank you for telling me that - it's very helpful to know your concerns."

Responding to overt feelings and emotions

In the example above, we use the accepting response to respond to a patient's belief. Acceptance is equally valuable as your initial response to feelings and emotions. For instance consider this accepting response to a bereaved patient saying of her dead husband "I'm so angry with him, how could he have left me alone like that; he didn't even make a will"

"So, you feel angry about being left alone and about the will, I can see that must be upsetting"

Pause (a 'full stop' gives the patient time/space to go on)

"Yes I am, I'm so alone and I get so cross with him for not being with me and then I feel guilty for being angry with him. Am I going mad, doctor?"

"Those are strong emotions to deal with - I'm glad you mentioned them"

Pause

An important part of the accepting response is to come to a <u>full stop</u> after giving the initial acknowledgement, to wait briefly and attentively in silence and to avoid saying "yes, but..." which automatically negates the acceptance. This is almost a knee jerk reaction for most of us. You can be so eager to help that instead of waiting you say "yes, but..." and go on to give your point of view or correction to erroneous thinking or your reassurance before you give the patient a chance to feel the acceptance or to say anything

further. All of this can come later, perhaps considerably later in the interview, *after* the patient has had an opportunity to respond to your statement of acceptance. It is of course imperative that you correct, advise and reassure; the question is when.

What happens if you make a full stop rather than adding the "but..." clause? Usually patients will respond with a brief outpouring of whatever thought or feeling has been acknowledged, share the burden or exhilaration, and get it "back" to a less overwhelming perspective so that they can talk about it further or go on to focus on other matters.

Acceptance is not agreement

Add in here why so helpful to the student and cut some of the rest

It is important to differentiate acceptance from agreement. Acknowledging that a patient would like further surgery is not the same as agreeing to perform it. It is a two stage process. First, identify and acknowledge a patient's beliefs without immediately countering: this enables you to understand the patient without provoking initial defensiveness. If the patients' thoughts do not fit with your own, later on in the consultation and after due consideration go to the second stage: offer your own perspective and correct mis-apprehensions.

Consider for example if the patient in the example given earlier were a 20 year old man. Contrast the following possible replies to his statement "I think I might have cancer: I've been getting an awful lot of wind lately":

"Oh, we all get wind but that's not a sign of cancer at your age, what exactly have you noticed?"
"Well, I've just felt more blown up after meals and keep passing wind in the evenings"
"That doesn't sound like anything to worry about"

This approach devalues the importance of the patient's views and although most probably correct, the reassurance comes too early in the consultation to be accepted by the patient. The patient will not be encouraged to propose his own theories in the future.

If instead, you follow the plan we proposed earlier:

"So, you're worried that the wind might be caused by cancer"
Pause
"Yes, doctor, you see my mother died of bowel cancer when she was 40 and I remember she had a lot of wind"
"I can understand your concern - we'll check that out carefully. Tell me a bit more about your symptoms and then I'll examine you to see if you're OK"

Here instead of countering the patient's view or giving premature reassurance, the importance to you of hearing the patient's concerns is emphasised. You can explain and correct mis-conceptions later.

Acceptance is the second stage in the three stage process of discovering patients beliefs:

1. **identification** - discover and listen to the patient's ideas, concerns and expectations
2. **acceptance** - acknowledge the patient's views and their right to hold them, without necessarily agreeing with them; then pause so the patient can say more
3. **explanation** - explain your understanding of the problem in relation to the patient's understanding and reach mutually understood common ground

The problem of premature reassurance

Acceptance also enables you to avoid the trap of premature reassurance. Simple reassurance by itself may not be an effective supportive response. Often reassurance is given before adequate information has been obtained, before patients' concerns have been discovered and before rapport has been developed. Unless you obtain sufficient information first, reassurance may sound false or in fact be inappropriately optimistic. Unless you understand your patients' fears, we may be addressing the wrong concern. Unless you have developed rapport with the patient, reassurance may well be interpreted as indifference or as being dismissive. And lastly, unless appropriate and relevant information is provided to back up our reassurance, patients will not understand the basis for your assertions. Acceptance prevents premature reassurance - by discovering and accepting the patient's concerns, trust is developed and more information can be obtained about the patient's illness and their concerns before an opinion is offered. Reassurance when it comes can then be appropriately timed, properly explained and matched to the patient's concerns.

Before you have collected further information or ordered tests you may not be in a position to provide reassurance that there is nothing to worry about. But you still have much to offer. You can accept the patient's concern and then use reassurance in other more appropriate ways. Instead of reassuring about the disease, you can for instance reassure the patient about your intent: you can offer your support by demonstrating that you wish to work with the patient and that you will give careful attention to their concerns.

EMPATHY

One of the key skills in building the relationship is the use of empathy. Empathy is a two stage process:

1. the understanding and sensitive appreciation of another person's predicament or feelings
2. the communication of that understanding back to the patient in a supportive way

The key to empathy is not only being sensitive but overtly demonstrating that sensitivity to the patient so that they appreciate your understanding and support. It's not good enough to think empathically, you must show it too. Empathy demonstrated in this way

overcomes the isolation of the individual in their illness and is strongly therapeutic in its own right. It also acts as a strong facilitative opening, enabling the patient to divulge more of their thoughts and concerns. What then are the building blocks of the empathic response?

Understanding the patient's predicament and feelings.
Many of the skills that we discuss throughout this book demonstrate to patients that you are genuinely interested in hearing about their thoughts. Together they provide an atmosphere which facilitates disclosure and enables the first step of empathy – understanding the patient's predicament – to take place:

- welcoming the patient warmly
- clarifying the patient's agenda and expectations
- attentive listening
- facilitation especially via paraphrasing of content and feelings and repetition
- encouraging the expression of feelings and thoughts
- picking up cues, checking out our interpretations or assumptions
- internal summary
- acceptance
- non-judgmental response
- use of silence
- encouraging the patient to contribute as an equal
- offering choices

Communicating empathy to the patient
The skills outlined above do not complete the second step of empathy, which is communicating your understanding back to the patient so that they know that you appreciate and are sensitive to their difficulty. Both nonverbal and verbal skills can help you here.

Empathic nonverbal communication can say more than a thousand words. Facial expression, proximity, touch, tone of voice or use of silence in response to a patient's expression of feelings can clearly signal to the patient that you are sensitive to their predicament. But what are the verbal skills that allow us to demonstrate empathy? Empathic statements are supportive comments that specifically link the "I" of the doctor and the "you" of the patient. They both name and appreciate the patient's affect or predicament.

- **I** can see that your husband's memory loss has been very difficult for **you** to cope with
- **I** can appreciate how difficult it is for **you** to talk about this
- **I** can sense how angry **you** have been feeling about your illness
- **I** can see that **you** have been very upset by her behaviour

- **I** can understand that it must be frightening for **you** to know the pain might keep coming back

It is not necessary to have shared an experience to empathise, nor to feel yourself that you would find that experience hard. It is necessary however to see the problem *from the patient's position* and communicate your understanding back to the patient.

SUPPORT

Several other supportive approaches contribute to relationship building and rapport formation. They are often used to complete the empathic response:

concern:

"I'm concerned that you'll be going home on your own tonight and might not be able to cope with your arm in a cast"

understanding:

"I can certainly understand how you might feel angry with the hospital for cancelling your operation"

willingness to help

"if there is anything else I can do for Jack, please let me know"

partnership

"we'll have to work together to get on top of this illness so let's work through the options that we can choose from"

acknowledging coping efforts and appropriate self care

"You've really done exactly the right things in trying to get his temperature down"
or
"I think you've coped really well at home despite some very considerable problems"

sensitivity:

"I'm sorry if this examination is embarrassing for you, I'll try to make it as quick and easy as I can"

The key point here is that our thoughts need to be verbalised to be supportive. Communication must be overt to be truly effective and not liable to mis-interpretation. Without explicit comment, the patient may well not be fully aware of your support.

INVOLVING THE PATIENT

SHARING OF THOUGHTS

Sharing one's thinking with the patient is another example of encouraging the patient's involvement:

> "What I'm thinking now is how to sort out whether this arm pain is coming from your shoulder or your neck "
> or
> "Sometimes it's difficult to work out whether abdominal pain is due to a physical illness or is related to stress."

Sharing one's thought processes in this way not only allows the patient to understand the reasons for your questions but also acts as a facilitative probe:

> "I think you might be right about stress, doctor, I've had a terrible time with my son just recently and I just don't know how to cope."

This overt approach allows the patient an insight into the process of the interview, enabling him to understand the drift of your questioning and providing a very open-ended method of eliciting further information. It is often more acceptable than thinking through the dilemma internally and then posing closed questions without explanation:

> "Are you under any stress at the moment?"

Closed questions so often feel unsettling to the patient because of uncertainty about what lies behind the doctor's choice of direction:

> "Does the doctor think I'm just neurotic?"

PROVIDING RATIONALES

Explaining the rationale for questions or parts of the physical examination is another specific example of the principle of reducing uncertainty. Many of your questions and examinations remain a mystery to the patient unless explained. When taking a history from a patient with chest pain, you might ask

> "How many pillows do you sleep with?"

This appears to the patient to be a complete non-sequitor. Why is this person asking him about his bed-time habits? Yet we could so easily have asked:

> "Do you get breathless when you lie flat at night?"

followed if necessary by
"Do you have to prop yourself up on several pillows?"

Similarly, without explaining why you are performing parts of the examination, you leave the patient in confusion and may even lay yourself open to medico-legal attack. The young female patient who comes in with a sore throat will be surprised if the male student starts to examine her groins unless he explains that she might have glandular fever and that he wishes to check for lymphadenopathy. The man with sciatica may be worried by the student who starts to test perineal sensation with a pin unless he explains about the danger of central prolapsed discs.

During physical examination, asking permission to perform each task is not only a matter of common courtesy but demonstrates to the patient that you are sensitive to their potential discomfiture and therefore promotes relationship building.