The patient-practitioner relationship

Practitioner and patient interpersonal skills

- Non-verbal communications:
  - It is the process of communication through sending and receiving wordless (mostly visual) messages between a practitioner and a patient during a consultation.
  - Argyle (1975) suggests that non-verbal communication is 4 times more powerful and effective as verbal communication, but it should match verbal communication.
  - Examples-
    - Paralanguage refers to the non-verbal aspects of speech such as the speed, flow and volume of the speech, the intonation used, the clarity of the words spoken and fitted (err or umm). These can help or hinder the passage of info. Rosental (1967) showed that when a doctor used an angry tone to persuade an alcoholic to have treatment, the patient's willingness decreased markedly.
    - Facial expressions are a very imp communication cue and many of the basic emotions are conveyed in the same way across the globe irrespective of culture.
    - Gestures can be used in conjunction with verbal communication and include hand movements, shrugging of the shoulders and using arms.
    - Personal invasion of space
    - Appearance can be a powerful cue to whether a patient will listen to and trust a practitioner. However, this can be dependent on the age of the patient.
  - The study by McKinstry and Wang (1991) looked at how acceptable patients found different styles of doctors' clothing and whether patients felt that this influenced their respect for his or her opinion. They dressed a male doc and a female doc in various outfits ranging from white coat to a casual shirt and jumper. Result: Most patients preferred the formal, white coat style as this was the most professional looking.

- Verbal communication
    - It is based around the speech used by a practitioner to try to gain access to relevant info about a patient's condition and then the potential treatment.
    - Medical jargon is one potential hindrance when it comes to verbal communications between doc and patient. McKinlay (1975) was the first to note that medical jargon can affect what the patient understands about the consultation. He investigated the use of terminology by women on a hospital maternity was. Fewer than 40% understood terms such as mucus, protein, umbilicus and suture. However, terms such a navel and breech were understood by many. The practitioners expected even fewer women to understand these terms but despite this they still used them.
    - Ley (1988) investigated what people remember about a consultation after consulting a practitioner. They were asked what the practitioner had told them to do and this was compared with what had actually been said. He found that:
        - Patients remembered about 55% of what was said
        - They remembered the first thing they were told (primary effect)
        - They remembered info that had been categorized
        - They remembered more if they had some medical knowledge

Patient and practitioner diagnosis and style

- A practitioner can use different styles to diagnose a patient which differ in the way info is collected and used to make the diagnosis.
- After analysing 2500 tape-recorded medical consultations in several countries including England, Holland, Ireland and Australia (all western countries so does not generalise to non-western countries. Ethical considerations- confidentiality), Byrne and Long (1976) distinguished firstly between a 'diagnostic phase' and a 'prescribing phase' and then went on to distinguish between 2 styles.
    - Doctor-centred style: the doc asked closed questions. When the patient attempted to expand on answers or tried to give more info, this was mainly ignored. It would appear that the doc wanted to make the symptom-diagnosis link with no extra communication

and everything was based on 'fact' rather than discussion and based on doc's professional expertise. Thus, the patient was passive.
    - Patient-centred style: doc asked open questions so that patient could explain and expand on answers. The doc would try to limit the use of medical jargon to ensure that the patient understood the diagnosis and potential treatment. The doc would encourage patients to express themselves how they wished and would ask for clarification as and when it was needed. Thus, the patient was active in the conversation.
- In 1990, Savage and Armstrong conducted a field experiment on 359 patients in a London medical practice. (ref to ocr booklet) The results showed that the style of consultation does affect patient satisfaction and higher levels of satisfaction were recorded for the directive style, particularly patients with physical problems.
- A medical practitioner hopes to correctly diagnose an ill person as ill and a well person as well. However, sometimes errors do occur:
    - Type I error- When the doc diagnoses somebody to be healthy when they are actually physically or psychologically ill. (Ill as well) This is considered to be the more serious error as it is medical negligence and the consequences for the person can very serious indeed.
    - Type II error- When the doc diagnoses somebody to be ill when they're actually not. (Well as ill) This means at the person might, for example, take some medicine for no reason. But, it is better to be safe than sorry and, if in doubt, it is better to diagnose illness. (not always) [Rosenhan study]
- In order to correctly diagnose, a medical practitioner needs info from a patient- self disclosure is revealing personal info to others. However, sometimes sensitive topics or potential embarrassment can hinder or prevent the patient from giving info to the doc. In order to overcome this, Robinson and West (1992) found that patients at a genitor-urinary clinic (specialises in venereal diseases) gave more info to a computer than they gave subsequently to the doc. Patients are less worried about social judgements and embarrassing details with a comp. They admitted having more sexual partners, having attended before and revealed more symptoms.

Misusing health services

- Safer et al (1979) found three types of delay in seeking treatment: (ref to ocr)
    - Appraisal delay- the time taken for the patient to recognise a symptom as a sign of illness
    - Illness delay- the time taken from deciding that one is ill to deciding to seek medical care
    - Utilisation delay- the time taken from deciding to seek medical care to actually getting it
- Hypochondrias
    - Individuals who have a tendency to overuse health services are often referred to as 'hypochondriacs" and are assumed to be malingering or else to be imagining symptoms that do not really exist. Sarafino (2006) stated that "Hypochondriacs have a tendency to worry excessively about their own health, to monitor their bodily sensations more closely than other people, make frequent unfounded medical complaints, and believe they are ill despite reassurances by physicians that they are not."
    - However, most hypochondriacs are interpreting benign symptoms (mild stress headache) as signs of a serious illness (brain tumour).
    - Thus, hypochondriasis is a preoccupation with health involving exaggerated concerns about having a serious illness.
    - Barlow and Durand (1995) present the case study of Gail. Minor symptoms (e.g. headache) would result in extreme anxiety that she had a serious illness because of newspaper and television reports. She avoided exercise and even laughing and noted anything that could be a symptom. Hearing about a real illness in her family would incapacitate her for days at a time. Doctors would always say, "There's nothing wrong with you; you're perfectly healthy."
- Munchausen's syndrome
    - It is a very rare disorder in which the individual repeatedly seeks out medical treatment by falsely claiming to have symptoms of serious illness.
    - It is known as a factitious disorder, which means that the patient is either consciously pretending to have symptoms that don't really

exist, or else deliberately harming themselves in order to produce symptoms.

- Another form of the disorder is Munchausen's by proxy. This is when a person induces or fakes the symptoms of an illness in another person in order for them to receive medical treatment. Affected mother makes child the victim and can inflict physical injuries and so this is also thought of as a form of child abuse.
- Munchausen's syndrome includes pathologic lying, peregrination (travelling or wandering), and recurrent, feigned or simulated illness.
- It could be that Munchausen's syndrome arises from an extreme need to seek attention. The treatment (based on the principle of operant conditioning) would be to ignore people with the condition and not offer them the reinforcement they crave; the danger with this approach is that the patient may escalate the self-harm in order to make treatment imperative. Another explanation is that as a result of past experience the patient has made a classical conditioning association between being cared for by medical staff and some kind of positive affect (e.g. feeling loved).
- Aleem and Ajarim (1995) presented the case study of a 22-year old female who had a painful swelling above her right breast. After many tests an infection was diagnosed and treatment began. Despite treatment the infection got worse and spread to the left breast area. A nurse found needles and a syringe full of faecal material, which the girl had been injecting into herself. Munchausen's syndrome was diagnosed.