

SUCCESSFUL DOCTOR-PATIENT COMMUNICATION AND RAPPORT BUILDING AS THE KEY SKILLS OF MEDICAL PRACTICE

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Summary. *When two people are able to relate to each other, they form a mutual bond and respect – rapport. Building a successful rapport is the single most important factor in building a relationship. As the key to successful office-patient relationships, it is important to know that rapport begins to develop right from the very first conversation the doctor has with the patient. In order to ensure that rapport can be established, the doctor needs to be cautious of how patients perceive him/her by judging not only verbal but also nonverbal communication. By demonstrating energy, enthusiasm, respect, empathy, caring, understanding of sensitive intercultural issues from the start, the doctor will be able to begin the rapport-building process that together with communication competence represent key skills of medical practice.*

Key words: *Communication, doctor, patient, rapport, medical practice*

1. Introduction

Patient-doctor communication is the building block upon which the physician's relationship with the patient is made (Nelson, 2008; Mauksch, 2008; Barret, 2006; Haftel, 2007). The medical interview, during which doctor-patient communication occurs, is a tool by which the physician gets to know the patient so that he/she feels like a person, not just a medical problem. By taking into consideration patient's problems, understanding him/her and the expectations that he/she has of the doctor, mutual satisfaction from healthy patient-doctor relationship becomes the wanted result. Therefore, both the verbal and nonverbal processes through which a doctor obtains and shares information with a patient is called doctor-patient communication. All patient-doctor interactions are influenced by the expectations of the both parties because this is always a two-way process. If the doctor has unfair expectations of the patient or if the interaction is affected by bias or unfair judgment the effective communication will never develop. Hence, the patient must feel at all times that he/she is treated with respect, that is, a partner in the communication process. Also, the patient's expectations of the doctor are that he/she is competent and uses all knowledge and expertise in the patient's best interests. Very often, patient's expectations go beyond clinical competence because patients expect the doctor to be respectful, polite, sincere, compassionate and interested, behave and dress like a professional, with the appropriate demeanor, avoiding judgmental behavior, with the proper verbal and nonverbal skills, that is, all traits that make up doctor's personal "signature".

2. Communication competence as touchstone for building a successful rapport

Studies, as Nelson indicates, primarily conducted in US hospitals with over half a million consultations that occur between general practitioners and their patients every working day in hospitals have shown that success in communication largely depends not only on the doctors' clinical knowledge and technical skills, but also on the nature of the rapport that is established between doctor and patient. As Nelson observes, the interviewed patients in the aforementioned studies singled out seven key traits alongside their own definitions that are considered to be fundamental to all clinicians:

Confident: *The doctor's confidence gives me confidence.*

Empathetic: *The doctor tries to understand what I am feeling and experiencing, physically and emotionally, and communicates that understanding to me.*

Humane: *The doctor is caring, compassionate, and kind.*

Personal: *The doctor is interested in me more than just as a patient, interacts with me, and remembers me as an individual.*

Frank: *The doctor tells me what I need to know in plain language and in a forthright manner.*

Respectful: *The doctor takes my input seriously and works with me.*

Thorough: *The doctor is conscientious and persistent.* (Nelson, 2008)

In the conducted surveys, patients pointed to the fact that the focus should be on the caring and trust required in relationships between clinicians and patients, so that ideas and decision-making can be shared when developing the visit agenda, discussing the nature and mean-

ing of disease, illness, and treatment options. (Nelson, 2008; Mauksch, 2008; Stewart, 1995; Williams, 1998; Brown, 2001). Another common complaint in the aforementioned studies had to do with doctors' use of complex terminology or medical language or as Nelson calls it "jargon" lacking simple words that patients easily comprehend. For example, "excise" which means "to remove by excision" or "resect" might be misunderstood whereas "cutting it out" sounds too painful. Using the verb "removing it" instead is a better way to convey the message without provoking stress in a patient. Moreover, some studies as indicated in PubMed, EMBASE, and PsychINFO from January 1973 to October 2006 also demonstrate that although rapport building and communication skills can be taught to clinicians, one or more of the aforementioned crucial elements (i.e. confidence, empathy, humanity, frankness etc.) are absent in most doctor-patient encounters. In May 1999, at a conference sponsored by the Bayer Institute for Health Communications and the Fetzer Institute and organized by the Association of American Medical Colleges in Cincinnati, an expert panel identified seven components

considered to be fundamental to all encounters between clinician and patient:

- Build the relationship
- Open the discussion
- Gather information
- Understand the patient's perspective
- Share information
- Reach agreement on problems and plans
- Provide closure

These points focus on overcoming barriers that can occur in communication and could enhance efficiency in doctor-patient communication, improve quality of care and time management. (Nelson, 2008) Thus, the purpose of communication becomes not just to deliver a message but to produce a change in both sender and receiver in view of their knowledge, attitude or behavior. The result of a successful communication is feedback both immediate and/or subsequent of both sender and receiver. Communicators should also be aware of the fact that positive feedback does not occur only through words, but also by attitudes, expressions and gestures, that is, nonverbal communication as well. In

Comprehensive Communications Model

Skill	Description
Skills With Ongoing Influence	
Rapport building and relationship maintenance	A strong clinician–patient relationship is essential for effective clinical encounters. A warm greeting, eye contact, a brief non-medical interaction, or checking on an important life event can build rapport in less than a minute.
Mindful practice	Attentive observation of the patient and of the clinician's own thought processes can guard against cognitive shortcuts and clinician domination of the agenda. Being present and critically curious can prevent the premature closure of a topic.
Topic tracking	In medical visits with multiple topics, discussions are often stopped and restarted as the patient and clinician juggle priorities. The probability that no clear decision will be made on a topic before the close of the visit is inversely proportional to the number of topics discussed.
Acknowledging social or emotional clues with empathy	Clues surface during every phase of the interview and signify thoughts or feelings that contribute to patient behavior or illness. The empathic acknowledgment of clues can encourage the patient to reveal beliefs about illness and treatment preferences, which can facilitate the creation of an effective plan.
Skills Used Sequentially	
Upfront, collaborative agenda-setting	It is not possible to address all concerns in detail in every visit. After initially checking in with the patient, an agenda for the visit should be created. This is much more efficient than addressing each issue as it surfaces, which is a more common approach.
Exploring the patient's perspective	Making an effort to understand the patient perspective during diagnostic investigations does not have to increase visit length, and it can help reduce patient anxiety, identify knowledge gaps, and improve adherence and outcomes.
Co-creating a plan	Complicated problems can benefit from shared and informed decision making. When patients are involved in creating a plan, they are more satisfied and have better outcomes, and their clinicians are less likely to generate unnecessary tests or referrals.

order to avoid misunderstandings and misinterpretations, that can break the communication process down completely, the authors, in an article by Mauksch *et al.* published in the *Archives of Internal Medicine* in July 2008, created a comprehensive communications model, directed at primary care providers, that blends the quality-enhancing and time-management features of selected communication and relationship skills with an aim to improve communication and overcome possible obstacles that occur in a doctor's office:

Moreover, communication skills together with sensitive intercultural issues that may rise during doctor-patient communication that are taught in medical schools in the US and practiced throughout a medical career are the keys to achieving the excellent care of the patient and building a patient-doctor rapport.

3. Initial steps for achieving successful communication and rapport building

Summarized below are some of the basic elements of communication during the medical interview/interaction with a patient that lead to a successful rapport building. It is by no means definite and does not require a particular style but it actually encourages the individual doctor to develop his/her own approach (Mauksch *et al.*, 2008; Nelson, 2008; Haftel, 2007; Stewart, 1995; Williams *et al.*, 1998; Krupat *et al.*, 2000; Roter *et al.*, 1992).

1. The first encounter or how to make a positive first impression?

The first impressions about people often turn into long-term perceptions and reputations. Within the first few seconds of meeting a new person, an opinion is formed based on the appearance, mannerisms and body language. These opinions are often difficult to overcome or undo, making the first encounter extremely significant. Accordingly, the first impression a doctor and a patient make of one another is the most important one. In those first few minutes in the room with the doctor, the patient will decide if he/she can feel comfortable sharing information with the doctor. In order to avoid building any sort of a barrier in interaction with the patient the doctor should pay particular attention to the following steps during the initial doctor-patient encounter.

Firstly, the doctor should prepare for the encounter by informing him/herself who the patient is by checking patient's medical record before he/she actually walks through the door and not in front of the patient (*e.g. Good morning Ms Michaels. How do you feel today?*). The doctor should make good eye contact, shake patient's hand and introduce him/herself using both first and last name. This is an indication of the doctor's role and a starting point for rapport building. The doctor should never have an assumption that the patient will immediately know who he/she is (*e.g. My name is Dr Gregory Lawrence, specialist in blood diseases.*). The

doctor should instinctively know that most patients will be nervous and uncomfortable meeting a doctor for the first time. Moreover, the doctor's job is to try in every way possible to relax the patient and make him/her comfortable by initially inquiring into non-medical areas of the patient's life, make the patient feel that he is a person who has come to the doctor's office to seek for help and, in the end, be helped. This will create common ground where both the patient and the doctor will feel comfortable (*e.g. Tell me Ms Michaels, what is your present occupation? How long have you been working there? What exactly are your duties?*). Once the doctor has established the initial step in building rapport with the patient, he/she can ask the patient to explain why they are there and let the patient tell their story in his/her own words (*e.g. Ms Michaels, could you please tell me what sort of problems have you been experiencing?*).

2. The course of the interview

The interview should start with the patient's explanation of the chief complaint and the history of present illness. In the course of this elaboration the doctor can question the patient by using open-ended questions which will allow the doctor to obtain the most information about the patient's problem (*Tell me more about your problem. Describe the pain for me. Is the swelling painful? Do you have a regular partner? What is troubling you the most about your condition? What kind of medicines are you taking at the moment?*). At the same time, it allows the patient to explain what is wrong and/or how he/she feels in their own words and tell the doctor everything they think is important. This can be followed by more direct close-ended questions used only if the open-ended questions do not provide the doctor with the information they intend to receive about the patient's medical condition (*Have you experienced this kind of pain before? Do you feel the pain anywhere else?*). The doctor only asks such questions in order to understand the problem. The doctor should, also, avoid asking questions that are too broad because the patient may not be quite sure what information the doctor is looking for (for example *Tell me about your present occupation*).

During an ongoing conversation with the patient, the doctor should take the opportunity to learn about the patient's family and social history (*How many members are there in your family? What activities do you participate in? Are there any stressors that may be contributing to your present condition? Will you have any support when a treatment plan is developed?*). This will help the doctor understand the patient better in the context of his/her illness and will enable him/her to treat the patient more effectively. It is often necessary throughout the course of the interview for a doctor to repeat the information he/she has received from the patient. (*e.g. So you have had this uncomfortable pain for a month now and it gets you really worried; Let us see if we can get you some medicine that will help you deal with this*

pain) and send feedback for confirmation. In this way, the patient will also know that he/she is being understood and listened to attentively by the doctor. Moreover, the patient will feel that someone cares and is determined to help him/her pull through.

3. Responding to the Patient

How the doctor responds to the patient during the whole course of the interview will determine not only how much information he/she will obtain, but will help build stronger rapport with the patient. The doctor needs to respond to the patient's both verbal and nonverbal cues in their perception of illness in a caring, humane and respectful way. This is called empathy and is considered the most important of all when dealing with the patient's feelings. Without it, the patient will never feel that the doctor understands and sympathizes with his/her situation and that the doctor will in due course of the interview eventually help them. By showing empathy, the doctor allows the patient to express his/her hidden fears about a condition or illness which is the best way to establish a steady fast rapport and accordingly build patient trust (*e.g. I'm really worried about this lump; It's completely natural for you to have worries. If you will let me ask you some questions now and we will see what we can do about it. I am sure that we can alleviate the problem.*). This point is crucial because patients often feel disclosed when they share their personal, sometimes even very sensitive information or problems they may be experiencing. When the patient reveals such information, the doctor should take a moment to think through carefully what the patient has revealed (*i.e. You mentioned a few moments ago that you feel anxious. Can you tell me more about the feeling?*). In the process, nonverbal language can reveal more than verbal, especially in a situation when the patient feels uncomfortable talking about sensitive issues with the doctor. For example, if the doctor is interviewing a patient who is very overwhelmed, he/she can say: *You seem quite upset. Can you tell me why you might feel that way?* at the same time carefully paying attention to the patient's nonverbal behavior that can reveal hidden emotions and/or fears.

From the cultural standpoint, the doctor, as the primary health care provider, must put aside his/her own view of things, beliefs and values and try not to project them onto the patient. Patient's medical problem is not about *the doctor*, but *the patient* who is most likely to have his/her own belief system. The doctor should, therefore, not judge the patient and try to put him/herself in the patient's shoes. The doctor should also be aware of and learn to control the nonverbal behavior that the patient might interpret in the wrong way (for instance making faces, frowning, nodding as a sign of disapproving) and always remember to treat patients as he/she would like to be treated. The key to effective nonverbal behavior is to treat the patient with respect and give him/her full attention. Moreover, doctor's attention, eye contact, body movements, touch, time-con-

sciousness will encourage the patient to be open with the doctor whose body language should show that he/she is also involved in rapport building. Recent literature shows that nonverbal behavior on the part of primary healthcare providers is very much related to patient satisfaction and rapport building making the most effective health counselors the ones whose nonverbal messages are congruent with their verbal messages. Thus, through this kind of interpersonal communication (meaning that only two persons take part in it), involving both verbal and nonverbal cues, doctors can create friendly and cooperative atmosphere with the patients. Interpersonal communication can help doctors get information about health problems of the patient and at the same time enable them to educate patients about family planning, contraception, communicable diseases etc. The following scenario in the doctor's office that involves the use of both verbal and nonverbal communication gives a clear picture of how doctor-patient communication and rapport is built:

Mrs. Davis is obviously overwhelmed. She has just learned that she has skin cancer. The doctor moves Mrs. Davis to a more private area of the office. Mrs. Davis indicates that the doctor, who originally prescribed the medication, was confusing when she talked about the possible side effects of the medication. The doctor goes over the possible side effects and explains what she should do if they occur. The doctor observes that Mrs. Davis looks confused. So, he/she stops and asks her if she understands, *Do you understand my instructions clearly Mrs. Davis?* She says she does. Even though she replies that she understands, the doctor provides a more thorough, detailed explanation. After this explanation, Mrs. Davis's facial expressions reveal that she understands. At one point during the conversation, the doctor placed his/her hand on Mrs. Davis's hand, looked into her eyes and said in a confidential tone, *I want to help you through this. Everything will be all right. The outcome of the treatment will be positive. Do not worry Mrs. Davis.* The doctor makes sure that his/her body movements and facial expressions are in accordance with words. That is, when the doctor says he/she is concerned he/she looks concerned. During the conversation, the doctor varies his/her tone, rate and volume. For example, the doctor noticed that Mrs. Davis tended to whisper the word cancer. Therefore, the doctor also lowered his/her voice whenever he/she used the word. The doctor used a soft, calm and even tone throughout the conversation as a means of comfort. (Bakić-Mirić, 2007)

Lastly, encouragement also represents a key trait that serves as a mode to strengthen the patient-doctor rapport. The doctor should encourage the patient's positive behaviors by praising (*e.g. It sounds like trying to avoid late-hour bingeing has been difficult for you, but I'm glad to hear you have not given up trying*) and letting them know that the he/she is doing the patient follow-up and most of all is being supportive and encouraging..

4. Collaborating with the patient

Once the doctor has gathered all the information from patient's history, physical exam and conducted laboratory tests, the time has come to explain what is the patient's problem (or at least several possible diagnoses he/she has made), what the next steps should be, either for further analyses that will enable the doctor to arrive at a diagnosis or initiation of a compliance plan and the course of treatment. The assessment of the patient's understanding of what the doctor is reporting should be done in a non-patronizing way by a simple question: *What will you tell your husband/wife about today's visit and our conversation?* The doctor should be able to see through the patient's feelings and/or concerns about the information received (e.g. *What is the first thing that comes to mind about this so far?*). Only then, that is after receiving patient's either positive or negative feedback, should the doctor respond appropriately and suggest the proper compliance instructions plan. Every healthcare provider must be sensitive to the patient's concerns, belief system, cultural issues and must explore any and every reason why the patient would not be comfortable with a suggested compliance plan (e.g. *What obstacles/factors would prevent you from being able to comply with this plan?*). Therefore, a doctor may need to start negotiating with the patient to arrive at a mutually acceptable course of action for treatment.

5. How to close the interview?

The end of the interview is the point when both the doctor and the patient need to understand what has happened during the course of it and what the plan for treatment is going to be. Summary of the doctor-patient encounter is the easiest way to do this. The doctor has to make sure that all questions, concerns and patient related needs have been fully addressed. On the part of both the doctor and the patient, it is also important that a rapport has been established because the patient needs to be able to rely on the fact that the doctor will be there in future if they should need him/her. Accordingly, the doctor should discuss with the patient the next steps in care, set up follow-up monitoring (if needed) or at least reassure the patient to feel free to come back to see him/her again. As far as compliance instructions are concerned, patients fully appreciate complete written instructions when they

leave the doctor's office. For instance, if the doctor says to take a certain medication three times a day, how should the patient handle nighttime? Can they take the medication at mealtime, on an empty stomach, or exactly when and how? Doubtful questions like these are the reason why the compliance instructions should be user-friendly and patient-centered.

4. Conclusion

Both verbal and nonverbal skills play a crucial role in face-to-face doctor-patient encounters. They create trust, understanding and build a successful rapport. In turn, they increase the willingness of patients to work with the healthcare team in person or by telephone or e-mail. Future studies of doctor-patient communication will demand effective training designs and should combine diverse methods to examine the rapport between doctor's verbal and nonverbal behaviors, time-consciousness, patient-doctor satisfaction and health outcomes. Accordingly, effective communication between doctor and patient will become a central clinical function and one of the first steps in building a successful rapport. Most of the core diagnostic information will arise from the compliance plan that will positively influence health outcome. At present, however, most complaints by patients about healthcare providers do not deal or point to their clinical competency or expertise but to communication problems. Studies have shown that only a small proportion of visits with doctors include any patient education and a surprisingly high number of patients do not understand or remember what their doctors tell them about diagnosis and treatment due to the insufficient communicative competence and extensive use of medical jargon. On the other hand, greater participation and involvement of patients in the encounter would also improve satisfaction, compliance and the outcome of treatment. Patients need to be encouraged to participate in making decisions about the management of their treatment plan, provided that they are informed properly and on time. Consequently, informed patients are likely to be more satisfied and possibly more compliant with doctor's recommendations because building a successful rapport largely depends upon the effectiveness of communication between patient and doctor, the validity of the patient expectations and the ability of the doctor to fulfill them.

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USPEŠNA KOMUNIKACIJA IZMEĐU LEKARA I PACIJENTA I USPOSTAVLJANJE DOBROG ODNOSA KAO KLJUČNE VEŠTINE MEDICINSKE PRAKSE

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Kratak sadržaj: Kada je dvoje ljudi u mogućnosti da se sporazumeju, oni stvaraju obostranu vezu i poštovanje koji se definišu kao odnos. Stvaranje dobrog odnosa je jedna od najvažnijih faktora u stvaranju veza između ljudi. Ključ uspešnog odnosa u ordinaciji, međutim, jeste uspostavljanje odnosa već prilikom prvog razgovora između lekara i pacijenta. Da bi se uspostavio dobar odnos, lekar mora da bude oprezan kako ga pacijenti sagledavaju, ne samo na osnovu verbalne već i neverbalne komunikacije. Ukoliko lekar demonstrira energičnost, entuzijizam, poštovanje, saosećanje, brigu, razumevanje za osetljiva interkulturalna pitanja od samog početka, uspeće da stvori odnos sa pacijentom koji zajedno sa kompetencijom u komunikaciji predstavlja ključnu veštinu u medicinskoj praksi.

Ključne reči: Komunikacija, lekar, pacijent/pacijentkinja, odnos, medicinska praksa