Hearing or listening? Respecting the voice of the patient through six simple techniques

Zachary I Merhavy[1,2], Thomas C Varkey[2], Christie Spann[3]

[1]Medical Student, Department of Medical Education, Ross University School of Medicine, Bridgetown, Barbados, [2]Adjunct Professor, Department of Neurology, The University of Arizona College of Medicine - Phoenix, Phoenix, Arizona, [3]Nurse, Department of Nursing, Corona Regional Medical Center, Corona, California

Physicians and health-care practitioners often hear the complaint that their patients do not feel heard. Many times, well-intentioned practitioners can come off as not caring or dismissive by making simple easy-to-fix errors in communication. Because of these errors, the emotional portion of the therapeutic relationship can be harmed. One place where this often is seen is in the initial history and physical examination – as the colloquial statement entails, "First impressions are everything." Herein, the authors provide some minor tips for improving the diagnostic utility of the history and physical examination of patients to improve the effectiveness and efficiency of care.

UTILIZING THE SPACE

Proxemics is the science of the use of space for utilizing the underlying beliefs and thoughts of a person to increase the levels of communication through non-verbal cues. This can often be seen when a person is forced to sit across from another at a desk in a teacher or professor's office. This use of space gives the idea that the person sitting across from the professor has a lesser role and that there is professional space between the two individuals talking to each other. One way that this often is seen in the patient rooms is when the physician or provider stands over the patient. This leads to there being an obvious power distance and physical distance between the two individuals. One technique which can be utilized is sitting during the patient interview, either on the edge of the patient bed or on a chair within the room. This signals to the patient both a desire to spend time listening to what the patient has to say and the idea that the two individuals are within the same power space allowing for an increase in patient trust [1].

ACTIVE LISTENING

One technique that is often utilized with clients and in mediation discussions is that of active listening. In active listening, after small portions of conversations clarifying questions, summaries of the discussion, and further information requests are made. Some examples include, "What I heard is…." or "What does ____ mean to you?," and minor noises demonstrating that the person is listening, "I see" or "Please continue." Through utilizing these phrases, the patient feels that they are being heard and can correct misunderstandings of what is being said by the physician or provider [2].

NAMING THE EMOTIONS

One technique that the palliative care specialty often utilizes in patient rooms is naming the emotion in the room [3]. This often allows the provider to properly frame how the patient is effectively experiencing the current situation which brought them to the hospital or from which they are suffering. "I see that you are worried" or "I hear the frustration in your voice" or "I understand that this is a difficult situation." Through utilizing these subjective and emotionally charged words in a non-judgmental way, the patient can feel as though the provider is able to understand the emotional aspects of the care being provided. Notabene, a presentation to the hospital for the patient is often the worst day that they have experienced, and emotional instability or ease of frustration is to be expected from those suffering.

DIVING DEEPER

The patient is a culmination of experiences that played a role in their health. Understanding the patient holistically, beyond their chief complaint or diagnosis, not only helps understand factors that affect the patient's health but also builds the provider-patient relationship. The provider's role goes beyond the scientific aspects of the patient's care and into the art of compassionate and empathic interactions. Compassionate-patient-centered care improves positive patient outcomes, the patient's attitude toward the medical team, and the patient's health behaviors. It is essential to consider the local community and that each patient's health goals are unique. The patient's health goals are often affected by their culture, sexuality, occupation, gender, education, age,

Access this article online	
Received - 27 June 2023 Initial Review - 04 July 2023 Accepted - 03 September 2023	Quick Response code
DOI: 10.32677/yjm.v2i3.4140	

Correspondence to: Thomas C Varkey, University of Arizona College of Medicine, Phoenix, Arizona. E-mail: thmsvrk7@gmail.com

family, religion, and society. Patients that the medical team would normally deem as noncompliant may have the desire to achieve their health goals, but they may not have the access or means to. Factors such as not having a proper means of transportation or their health insurance not covering the brand name medication can hinder the patient. Asking these types of questions about their life can provide a better perspective on how to cocreate a patient-centered health plan. Cocreating a health plan allows for the patient's health needs and desires to be addressed while adhering to medical evidenced-based processes of the provider and interdisciplinary team.

SUMMARIZATION AND GIVING NEXT STEPS

Once the history and the physical examination have been performed, a therapeutic alliance can be furthered if the patient is informed of the provider's understanding of the patient's condition and the next steps that the provider will be taking. These next steps can even include statements of, "I'm going to review your laboratories and imaging and then plan what to do." Even a statement of processing can provide an air of compassion and care, improving the subjective understanding of the provider. Many patients describe how knowing that the provider is taking active steps and has included them in their planning improves their views of their care [4].

"WHAT QUESTIONS DO YOU HAVE?"

This last phrase is very specifically worded, which provides room for the patient to give their questions of what the disease state entails and what the provider intends to do. Due to the open nature of this particular last statement of the provider encounter, the patient is encouraged to actively take part in their care [5]. If there are no questions developed during this portion of the interview, the patient can be encouraged to write down questions that they might develop later after the initial encounter and those answered during repeat encounters. This particular portion of the interview should be considered to the provider to be equally as important to the remainder of the history and physical examination.

In conclusion, through utilization of these techniques within the patient interview, the provider is often able to improve the efficiency of the overall hospitalization through narrowing the differential based on what the patient says, increase the patient trust through actively engaging with their emotions, and non-biasedly understand both the chief complaint and the next steps need provide care. In understanding what the patient truly has to say, the patient remains the central focus of the encounter, not just his or her disease state.

REFERENCES

1. Swayden KJ, Anderson KK, Connelly LM, *et al*. Effect of sitting vs. Standing on perception of provider time at bedside: A pilot study. Patient Education and counseling 2012;86:166-71.
2. Tallman K, Janisse T, Frankel RM, *et al*. Communication practices of physicians with high patient-satisfaction ratings. Perm J 2007;11:19-29.
3. Datta-Barua I, Hauser J. Four communication skills from psychiatry useful in palliative care and how to teach them. AMA J Ethics 2018;20:E717-23.
4. Lis CG, Rodeghier M, Gupta D. Distribution and determinants of patient satisfaction in oncology: A review of the literature. Patient Prefer Adherence 2009;3:287-304.
5. Coleman C, Salcido-Torres F, Cantone RE. "What questions do you have?": Teaching medical students to use an open-ended phrase for eliciting patients' questions. Health Lit Res Pract 2022;6:e12-6.

Funding: None; Conflicts of Interest: None Stated.

How to cite this article: Merhavy ZI, Varkey TC, Spann C. Hearing or listening? Respecting the voice of the patient through six simple techniques. Yemen J Med. 2023;2(3):122-123.