CONTENTS

SECTION

Principles of Practice

CHAPTER 1

Initial Assessment and Communication

Jonathan S. Berek, Paula J. Adams Hillard

KEY POINTS

1. We are all products of our environment, our background, and our culture. The importance of ascertaining the patient's general, social, and familial situation cannot be overemphasized. The physician should avoid being judgmental, particularly with respect to questions about sexual practices, gender identity, and sexual orientation.
2. Good communication is essential to patient assessment and treatment. The foundation of communication is based on key skills: empathy, attentive listening, expert knowledge, and rapport. These skills can be learned and refined.
3. The concepts of medical professionalism initially codified in the Hippocratic Oath demand that physicians be circumspect with all patient-related information. For physician–patient communication to be effective, the patient must feel that she is able to discuss her problems in depth and in confidence.
4. Different styles of communication may affect the physician's ability to perceive the patient's status and achieve the goal of optimal assessment and successful treatment. The intimate and highly personal nature of many gynecologic conditions requires particular sensitivity to evoke an honest response.
5. Some patients lack accurate information about their illnesses. Incomplete or inadequate understanding of an illness can produce increased anxiety, dissatisfaction with medical care, distress, coping difficulties, unsuccessful treatment, and poor treatment response.
6. After a dialogue is established, the patient assessment proceeds with obtaining a complete history and typically, performing a physical examination. Both of these aspects of the assessment rely on good patient–physician interchange and attention to details.
7. At the completion of the physical examination, the patient should be informed of the findings. When the results of the examination are normal, the patient can be reassured accordingly. When there is a possible abnormality, the patient should be informed immediately; this discussion should take place after the examination, with the patient clothed.

The practice of gynecology requires many skills. In addition to medical knowledge, the gynecologist should develop interpersonal and communication skills that promote patient–physician interaction and trust. The assessment must be of the "whole patient," rather than confined to her general medical status. It should include any apparent medical conditions and the psychological, social, and family aspects of her situation. **To view the patient in the appropriate context, environmental and cultural issues that affect the patient must be taken into account.** This approach is valuable in routine assessments, and in the evaluation of specific medical conditions, providing opportunities for preventive care and counseling on an ongoing basis.

VARIABLES THAT AFFECT PATIENT STATUS

Many external variables exert an influence on the patient and on the care she receives. Some of these factors include the patient's "significant others"—her family, friends, and personal and intimate relationships (Table 1-1). **These**

Table 1-1 Variables That Influence the Status of the Patient

Patient
Age
History of illness
Attitudes and perceptions
Sexual orientation
Habits (e.g., use of alcohol, tobacco, and other drugs)
Family
Patient's status (e.g., married, separated, living with a partner, divorced)
Caregiving (e.g., young children, children with disabilities, aging parents)
Siblings (e.g., number, ages, closeness of relationship)
History (e.g., disease)
Environment
Social environment (e.g., community, social connectedness)
Economic status (e.g., poverty, insuredness)
Religion (e.g., religiosity, spirituality)
Culture and ethnic background (e.g., first language, community)
Career (e.g., work environment, satisfaction, responsibilities, stress)

external variables include psychological, genetic, biologic, social, and economic issues. Factors that affect a patient's perception of disease and pain and the means by which she has been taught to cope with illness include her education, attitudes, understanding of human reproduction and sexuality, and family history of disease (1–3). Cultural factors, socioeconomic status, religion, ethnicity, language, age, gender identity, and sexual orientation are important considerations in understanding the patient's response to her care.

We are all products of our environment, our background, and our culture. The importance of ascertaining the patient's general, social, and familial situation cannot be overemphasized (4,5). Cultural sensitivity may be particularly important in providing reproductive health care (6).

1 The context of the patient's support system and family can and should be ascertained directly. The family history should include a careful analysis of those who had significant illnesses, such as cancer or an illness that the patient perceives to be a potential explanation for her own symptoms. The patient's perspective of her illness can provide important information that guides the physician's judgment; specific questioning to elicit this perspective can improve satisfaction with the interaction (4,7). The patient's understanding of key events in the family medical history and how they relate to her is important. The patient's sexual history, sexual orientation, relationships, and practices should be understood, and her functional level of satisfaction in these areas should be determined. **The physician should avoid being judgmental, particularly with respect to questions about sexual practices, gender identity, and sexual orientation** (see Chapter 17).

COMMUNICATION

2 **Good communication is essential to patient assessment and treatment.** The patient–physician relationship is based on communication conducted in an open, honest, and careful manner that allows the patient's situation and problems to be accurately understood and effective solutions developed collaboratively. Good communication requires patience, dedication, and practice and involves careful listening and attention to verbal and nonverbal communication.

The foundation of communication is based on four key skills: empathy, attentive listening, expert knowledge, and the ability to establish rapport. These skills can be learned and refined (4,5,8). When the initial relationship with the patient is established, the physician must vigilantly pursue interviewing techniques that continue to create opportunities to foster an understanding of the patient's concerns. Trust is the fundamental element that encourages open communication of the patient's feelings, concerns, and thoughts, rather than withholding information (9).

One very basic element of communication—sharing a common language and culture—may be missing when a clinician interacts with a patient of limited or no English proficiency. Language concordance between the physician and patient is assumed in many discussions of communication. More than 21% of Americans speak a language other than English at home, and of these 41% reported to the Census Bureau that they speak English less than very well (10). Language barriers are associated with limited health literacy, compromised interpersonal care, and lower patient satisfaction in health care encounters (11,12). While language-concordant health care professionals are optimal, in-person medical interpreters can mitigate these effects; video and telephonic interpretation provide technologic solutions that help mitigate communication challenges with individuals of limited English proficiency (13). The State of California recognized the importance of communication in patient–physician interactions through a provision in the Health and Safety Code that states "where language or communication barriers exist between patients and the staff of any general acute care hospital, arrangements shall be made for interpreters or bilingual professional staff to ensure adequate and speedy communication between patients and staff" (14). Training future physicians to work with interpreters is receiving increasing attention in US medical schools and will contribute to improved clinical practice and reduce health care disparities (15).

3 Although there are many styles of interacting with patients, each physician must determine and develop the best way that she or he can relate to patients. Physicians must convey that they are able and willing to listen and that they receive the information with utmost confidentiality (1,4). **The concepts of medical professionalism initially codified in the Hippocratic Oath demand that physicians be circumspect with all patient-related information.** The Health Insurance Portability and Accountability Act (HIPAA), which took effect in 2003, established national standards intended to protect the privacy of personal health information. Initial fears expressed about the impact of HIPAA regulations and the potential for legal liability led to discussions of appropriate communication and physicians' judgments based on the ethical principles of confidentiality in providing good medical care (16,17) (see Chapter 2).

Communication Skills

It is essential for the physician to communicate with a patient in a manner that allows her to continue to seek appropriate medical attention. The words used, the patterns of speech, the manner in which words are delivered, even body language and eye contact, are all important aspects of the patient–physician interaction. The traditional role of the physician was paternalistic, with the physician expected to deliver direct commands or "orders" and specific guidance on all matters (5). Now patients appropriately demand and expect more balanced communication with their physicians. Although they may not have equivalent medical expertise, they do expect to be treated with appropriate deference, respect, and a manner that acknowledges their personhood as equal to that of the physician. Doctor–patient communication is receiving more attention in medical education and is being recognized as a major task of lifelong professional learning and a key element of successful health care delivery (18).

Patients with rare or unusual conditions sometimes have more specific medical knowledge of a given medical problem than the physician does. When this is the case, the physician must avoid reacting defensively. A 2013 poll indicated that one-third of Americans had researched symptoms or diagnoses online; 46% of those individuals reported that their online research led them to seek medical care, while 38% decided to manage their suspected health conditions without consulting a clinician (19). The patient often lacks broader knowledge of the context of the problem, awareness of the variable reliability of electronic sources of information, the ability to assess a given study or journal report within a historical context or in comparison with other studies on the topic, knowledge of drug interactions, an ability to maintain objective intellectual distance from the topic, or essential experience in the art and science of medicine. The physician possesses these skills and extensive knowledge, whereas the patient has an intensely focused personal interest in her specific medical condition. Surveys of physicians' perceptions of the impact of Internet-based health information on the doctor–patient relationship found positive and negative perceptions; physicians express concerns about a hindrance to efficient time management during an office visit, but a positive perception of the potential effects on the quality of care and patient outcomes (20). **A collaborative relationship that allows patients greater interactive involvement in the doctor–patient relationship can potentially lead to better health outcomes** (21–23).

Physician–Patient Interaction

The pattern of the physician's speech can influence interactions with the patient. Some important components of effective communication between patients and physicians are presented in Table 1-2. There is evidence that scientifically derived and empirically validated interview skills can be taught and learned, and conscientious use of these skills can result in improved outcomes (24). A list of such skills is found in Table 1-3.

For physician–patient communication to be effective, the patient must feel that she is able to discuss her problems in depth and in confidence. Time constraints imposed by the pressures of office scheduling to meet economic realities make this difficult; both the physician and the patient frequently need to reevaluate their priorities. If the patient perceives that she participates in decision making and that she is given as much information as possible, she will respond to the mutually derived treatment plan with lower levels of anxiety and depression, embracing it as a collaborative plan of action. She should be able to propose alternatives or modifications to the physician's recommendations that reflect her own beliefs and attitudes. There is ample evidence that patient communication, understanding, and treatment outcomes are improved when discussions with physicians are more dialogue than lecture. When patients feel they have some room for negotiation, they tend to retain more information regarding health care recommendations. The concept of collaborative planning between patients and physicians is embraced as a more effective alliance than the previous model in which physicians issued orders. The patient thus becomes more vested in the process of determining health care choices. For example, decisions about the risks and benefits of menopausal hormone therapy must be discussed in the context of an individual's health and family history, including her personal beliefs and goals. The woman decides whether the potential benefits outweigh the potential risks, and she is the one to determine whether or not to

Table 1-2 Important Components of Communication Between the Patient and Physician: The Physician's Role

The Physician Is:
A good listener
Empathetic
Compassionate
Honest
Genuine
Respectful
Fair
Facilitative
The Physician Uses:
Understandable language
Appropriate body language
A collaborative approach
Open dialogue
Appropriate emotional content
Humor and warmth
The Physician Is Not:
Confrontational
Combative
Argumentative
Condescending
Overbearing
Dogmatic
Judgmental
Paternalistic

Table 1-3 Behaviors Associated With the 14 Structural Elements of the Interview[a]

Preparing the Environment	**Negotiating a Priority Problem**
Create privacy	Ask the patient for priorities
Eliminate noise and distractions	State own priorities
Provide comfortable seating at equal eye level	Establish mutual interests
Provide access	Reach agreement on order of addressing issues
Preparing Oneself	**Developing a Narrative Thread**
Eliminate distractions and interruptions	Develop personal ways of asking the patient to tell her story
Focus	Ask when last felt healthy
Self-hypnosis	Ask about entire course of illness
Meditation	Ask about recent episode or typical episode
Constructive imaging	**Establishing the Life Context of the Patient**
Let intrusive thoughts pass through	Use first opportunity to inquire about personal and social details
Observation	Flesh out developmental history
Create a personal list of categories of observation	Learn about the patient's support system
Practice in a variety of settings	Learn about home, work, neighborhood, safety
Notice physical signs	**Establishing a Safety Net**
Presentation	Memorize complete review of systems
Affect	Review issues as appropriate to specific problem
What is said and not said	**Presenting Findings and Options**
Greeting	Be succinct
Create a personal stereotypical beginning	Ascertain the patient's level of understanding, cognitive style
Introduce oneself	Ask the patient to review and state understanding
Check the patient's name and how it is said	Summarize and check
Create a positive social setting	Tape record and give the tape to the patient
Introduction	Ask the patient's perspectives
Explain one's role and purpose	**Negotiating Plans**
Check the patient's expectation	Activate the patient
Negotiate about differences in perspective	Agree on what is feasible
Be sure expectations are congruent with the patient's	Respect the patient's choices whenever possible
Detecting and Overcoming Barriers to Communication	**Closing**
Develop personal list of barriers to look for	Ask the patient to review plans and arrangements
Include appropriate language	Clarify what to do in the interim
Physical impediments such as deafness, delirium	Schedule next encounter
Include cultural barriers	Say goodbye
Recognize the patient's psychological barriers, such as shame, fear, and paranoia	
Surveying Problems	
Develop personal methods of initiation of problem listing	
Ask "What else?" until problems are elicited	

[a] **Lipkin M Jr.** Physician–patient interaction in reproductive counseling. *Obstet Gynecol* 1995;88:31S–40S.

Derived from **Lipkin M, Frankel RM, Beckman HB, et al.** Performing the interview. In: **Lipkin M, Putnam SM, Lazare A,** eds. *The Medical Interview: Clinical Care, Education, and Research.* New York: Springer-Verlag; 1995:65–82.