Factors of Trust: The Role of Interpersonal Communication and Physical Touch on the Patient-Physician Relationship

by
Daniel Trinh

A THESIS

submitted to

Oregon State University

University Honors College

in partial fulfillment of
the requirements for the
degree of

Honors Baccalaureate of Science in Biochemistry & Molecular Biology
(Honors Scholar)

Presented on May 6, 2019
Commencement June 2019

AN ABSTRACT OF THE THESIS OF

Daniel Trinh for the degree of Honors Baccalaureate of Science in Biochemistry & Molecular Biology presented on May 6th, 2019. Title: Factors of Trust: The Role of Interpersonal Communication and Physical Touch on the Patient-Physician Relationship

Abstract approved:

_____

Courtney Campbell

The physician-patient relationship is one that relies heavily on the premise of trust. In contemporary medicine, trust is difficult to sustain due to the distractions created by technological documentation, rules, an increasing number of patients seen by a fewer physicians that diminish the human interaction within the relationship. To emphasize the importance of bringing the humanities back to medicine, Dr. Abraham Verghese tells of a story where his non-compliant, terminally-ill patient became compliant just before Dr. Verghese began his routine physical exams. Virtually meaningless as a treatment itself, it nevertheless indicates the notion of care being provided. This research looks to further explore how physicians employ interpersonal communication skills and physical touch and how they affect the development of the patient-physician relationship. This question was investigated through an analysis of primary literature, followed by interviews with ten physicians to better understand the physician perspective. Current literature describes the significance of general effective communication skills and barriers, along with the role of utilizing physical touch to develop a more trusting relationship with the patient. Furthermore, the physician interviews expanded on the individuality of each patient interaction. This shows the need for social and emotional awareness on the part of the physician, as well as a responsibility to be effective communicators, and the necessity of establishing a patient-oriented delivery of healthcare.

Key words: patient-physician relationship, medical technology, physical touch, interpersonal communication

Corresponding email address: trinhd@oregonstate.edu

Factors of Trust: The Role of Interpersonal Communication and Physical Touch on the Patient-Physician Relationship

by
Daniel Trinh

A THESIS

submitted to

Oregon State University

University Honors College

in partial fulfillment of
the requirements for the
degree of

Honors Baccalaureate of Science in Biochemistry & Molecular Biology
(Honors Scholar)

Presented on May 6, 2019
Commencement June 2019

Honors Baccalaureate of Science in Biochemistry & Molecular Biology project of Daniel Trinh presented on May 6, 2019.

APPROVED:

_____

Courtney Campbell, Mentor, representing the School of History, Philosophy, and Religion

_____

Stephanie Jenkins, Committee Member, representing the School of History, Philosophy, and Religion

_____

Hannah Fine, Committee Member, representing Osteopathic Neuromusculoskeletal Medicine

_____

Toni Doolen, Dean, Oregon State University Honors College

I understand that my project will become part of the permanent collection of Oregon State University, Honors College. My signature below authorizes release of my project to any reader upon request.

_____

Daniel Trinh, Author

Acknowledgments

I would like to begin by expressing my utmost gratitude to Dr. Courtney Campbell. Without his kindness and dedication to education, I would not have had an opportunity to complete my thesis. I came to him scrambling to find a new mentor near the end of my junior year. Despite preparing to leave for his year of sabbatical, he graciously agreed to mentor me in this project. I cannot express how grateful I am of his time and devotion to my project. Thank you for allowing me the opportunity to learn how not only to be a better doctor, but to be a better person.

Secondly, I would like to thank Dr. Stephanie Jenkins and Dr. Hannah Fine for agreeing to be a part of my committee. In the relatively short time that I have known them, they immediately struck me as passionate individuals who genuinely care for the wellbeing of others. Dr. Jenkins's disability studies course has been one of my favorites here in college, and her passion is simply contagious. While shadowing Dr. Fine, her technical knowledge along with her abilities to lead and relate to others inspired me from day one. Thank you both for influencing me to be a more well-rounded individual, and I appreciate your time and interest in my project.

Finally, I thank my mom, dad, and brother for their endless support. While they may not know it, to me they embody the notions of selflessness, determination, and humility. As immigrants to the United States, their transition saw much adversity. With their hard work and many sacrifices, they have given me the privilege of having food, shelter, education, and loving support. Each of their stories is a humbling one, and they only make me more grateful for everything that they have done for me. I would like to dedicate this thesis to these people who have inspired me to always better myself, and to do it with altruism and passion.

Table of Contents

Personal Statement

From an early age, my parents instilled the notion of selflessness in my mind as a core value. In my Vietnamese-American culture, our family holds true to the practice of caring for others before oneself. Entering college as an aspiring engineer, I had put medicine in the back of my mind as the goals I had for my career derived from a more materialistic mindset. As I progressed through the early courses of engineering, I quickly realized that I was not happy about where this path would be taking me. My interest in engineering and my dreams to design materials quickly diminished as I began to engage with more people throughout college.

I began weight training in my second term of college as simply a stress relief method. With consistency and hours of researching exercise science and muscle anatomy and physiology, I began to make progress, both mentally and physically. My peers took notice and asked to join me in the gym. Soon enough, I found myself writing workout plans, teaching lifting technique, and helping friends take the appropriate steps in achieving their fitness goals. So what have I done? I turned myself into an amateur trainer, right? No, it was much more than that; through science and a newly-found interest in teaching, I equipped my peers with tools to improve themselves. It became clear to me that my passions lie within human interaction - the passion of empowering others to help them achieve their goals.

While I value the power of technology in medicine today, it is becoming clear that the humanitarian aspect of medicine is slowly diminishing. With many barriers in place, doctors may easily lose sight of the significance in having a humanistic interaction with their patients. This thesis will study the physician's perspective of how interpersonal communication and physical touch affect the patient-physician relationship as well as patient health outcomes.

Chapter 1: Starting From the Basics

A cough, bruise, runny nose, or even an abnormal blood pressure can easily be observed without the requirement of a medical degree. In fact, our physicians today are so qualified and experienced, they are able to diagnose patients within minutes of their encounters with patients. Additionally, with the assistance of technology, physicians are able to easily observe and manage these ailments in a rather systematic fashion. In a world of sickness and disease, the demand for doctors has never been so high. This systematic style of seeing patients is reminiscent of an assembly line, where the patients come to the doctor in outrageous volumes, and physicians work for excessive hours each day. Perhaps, with the first few patients, the care is given more cautiously as the new doctor is still learning and seeing patients for the first time. However, as time becomes a factor, and similar symptoms arise, the doctor begins to notice patterns and defaults to diagnosing based on the patterns they recognize. This systematic and "quick" approach to medicine fails to recognize each patient as a unique and individualized case, often leading to misdiagnosis, or more fundamentally, failure to observe a key sign.

In his 2011 TED talk called, "A Doctor's Touch," Dr. Abraham Verghese from Stanford University tells a story of a woman presenting to the hospital with an outrageous blood pressure of two-hundred thirty over one-hundred seventy. She quickly went into cardiac collapse, but was then resuscitated and sent to undergo a CAT scan. The doctors were initially suspicious of potential blood clots in her lung, yet there were no signs of such. The scan actually revealed "bilateral, visible, palpable breast masses" (Verghese, 2011). Doctors then identified these masses as tumors that had metastasized throughout the entire body. As gloomy of a finding this is, one must wonder, how could these visible, palpable masses possibly had not been noticed before they had reached this point of metastasis? The most devastating part of this story is that

this patient visited "four or five" other healthcare institutions within the previous two years of this occurrence. As Verghese elaborates, these were "[f]our or five other opportunities to see the breast masses, touch the breast mass, [and] intervene at a much earlier stage [...]." How could these trained professionals miss such a glaringly obvious sign in each of these four or five instances? Without the accessibility of that CAT scan, would anyone have noticed such masses?

"Ladies and gentlemen, that is not an unusual story. Unfortunately, it happens all the time. I joke, but I only half joke, that if you come to one of our hospitals missing a limb, no one will believe you till they get a CAT scan, MRI or orthopedic consult. I am not a Luddite. I teach at Stanford. I'm a physician practicing with cutting-edge technology. But I'd like to make the case to you in the next seventeen minutes that when we shortcut the physical exam, when we lean towards ordering tests instead of talking to and examining the patient, we not only overlook simple diagnoses that can be diagnosed at a treatable, early stage, but we're losing much more than that. We're losing a ritual. We're losing a ritual that I believe is transformative, transcendent, and is at the heart of the patient-physician relationship. This may actually be heresy to say this at TED, but I'd like to introduce you to the most important innovation, I think, in medicine to come in the next ten years, and that is the power of the human hand -- to touch, to comfort, to diagnose and to bring about treatment" (Verghese, 2011).

Today's physicians have access to the latest cutting-edge technology to help them make more precise and accurate diagnoses, and reliance on these devices slowly becomes more of a significant factor in the patient-physician relationship. As the basis of Dr. Verghese's talk, he mentions how physicians are relying more on machines to uncover answers regarding their patients, rather than listening to the patients themselves. For example, the initial approach to internal pains has changed over time. In times with limited technology, the first objective to resolving the mystery is to use the most accessible tools a physician has: the hands. Doctors would feel and palpate the area to observe any abnormalities. While this method is certainly more subjective, it is still the easiest way to find any obvious abnormalities, such as a nodule or tenderness in the area. In more modern medicine, it seems as if the initial action from the physician is to look without touching, ask a barrage of questions, and then prescribe an imaging

test to reveal any structural abnormalities. Although an imaging test would allow for a much more precise observation of the area, it is expensive, and may reveal "abnormalities" that may not actually be clinically significant.

Furthermore, the component of touch is completely lost. Touch, whether it be a physical examination or simply a handshake, carries significant weight in developing the patient-physician relationship. Using physical touch breaks the initial barrier between two strangers. Typically, the patient would visit a physician when they are ill or are in pain. Therefore, they are entrusting their health in the physician. Dr. Verghese goes on to talk about the ritual, known as the physical examination in his practice. He calls this a ritual because it is indicative of a transformation, much like the ritual of marriage, or the ritual of a life passing. In the case of the patient-physician relationship, the physical examination indicates the transformation of a doctor and a patient into two humans, thus establishing a mutual trust among both parties. Verghese explains that by bypassing the ritual of a physical examination, then we "have bypassed on the opportunity to seal the patient-physician relationship." Even in the case of a terminally-ill patient where such an examination would almost certainly provide no valuable information, Dr. Verghese still performs the examination as it is a ritual, as it establishes trust - something a machine will never be able to achieve.

In the modern age of medicine and healthcare, many protocols must be followed by the physician, required by law and insurance companies. Doctors have been groomed by the potential dangers of lawsuits and finances to follow specific procedures. One of these procedures entails a thorough history taken by the doctor. However, patients have also found that these general questions have become a nuisance since they are asked repeatedly in one visit to the doctor's office - once by the nurse, then once again by the doctor. Compounded with the

likelihood that the doctor is running behind schedule, we can quickly see how patients and doctors feel that their interactions are so brief, with the doctors always seeming to fight the clock. A forty-five minute appointment soon becomes a five-minute opportunity for the patient to describe all of their reasons for coming in, and then for the doctor to address each issue.

Further emphasizing the significance of establishing a relationship between patient and physician, we often find doctors with their backs to the patient, attention fixated on a computer screen, and blindly firing general questions at the patient. It can be frustrating for patients when they feel that their time is wasted every time coming to the doctor's office. With the ease of access to endless information online, patients today seem to be more inclined to quickly search their symptoms online in order to diagnose themselves in minutes, rather than spending an hour in the doctor's office only to be told to come back since they are out of time. It is difficult to establish a relationship with anyone if you are limited to only a fifteen-minute interaction. Additionally, the physician's etiquette becomes a barrier on top of time as well. Without making eye-contact and appropriately using interpersonal communication skills, establishing a trusting relationship is virtually impossible.

Dr. Verghese tells an inspiring story from Sir Arthur Conan Doyle, the creator of the famous detective, Sherlock Holmes. This character was inspired by one of his teachers, Dr. Joseph Bell, who was a master of observation and logical deduction. The story tells of a patient with her son coming to seek out medical attention. Before the woman was even able to introduce herself, Dr. Bell was able to deduce where she had come from, that she had another child aside from the one she brought, where she worked, and the path that she took to get to the infirmary.

"[Bell] says, 'You see, when she said, 'Good morning,' I picked up her Fife accent. And the nearest ferry crossing from Fife is from Burntisland. And so she must have taken the ferry over. You notice that the coat she's carrying is too small for the child who is with her, and therefore, she started out the journey with two children, but dropped one off along the way. You notice the clay on the soles of her feet. Such red clay is not found within a hundred miles of Edinburgh, except in the botanical gardens. And therefore, she took a short cut down Inverleith Row to arrive here. And finally, she has a dermatitis on the fingers of her right hand, a dermatitis that is unique to the linoleum factory workers in Burntisland,'" (Verghese, 2011).

The power of deduction is a vital tool that is becoming lost with the rise of medical technology. However, the purpose of this story is not to fixate on the need for all doctors to become a variation of Sherlock Holmes, but rather serves to explain that the most important information lies within the patient themselves, not just the images and information that summarize them in a machine. Verghese's discussion provides the basis for the core questions of my thesis: (1) How are interpersonal communication skills and physical touch essential to an effective patient-physician relationship? (2) How can these skills be best utilized to provide for better delivery of health care?

Methodology

The approach of this thesis qualitatively analyzes the significance of interpersonal communication skills and physical touch in regard to the development of the patient-physician relationship, and how healthcare may be best delivered. This work observed the patient-physician relationship through the scope of primary literature, followed by interviews with various doctors, providing a deeper analysis of the relationship with an emphasis on the physician perspective.

In regard to the physician perspective, the interviewees were doctors within the personal networks of Dr. Courtney Campbell and Daniel Trinh. The questions to be asked were designed to be anecdotal and allowed physicians to elaborate on their personal experiences, rather than

generalized ideologies. Common themes were then analyzed from both the primary literature and interviews, ultimately leading to a conclusion. This thesis project involves research activity that requires Institutional Review Board approval, in which an application has been submitted prior to research.

Expected Results/Anticipated Outcome and Significance

We anticipate the research will show common themes of trust and the significance of building a relationship between the patient and physician. Exploring the significance of interpersonal communication and physical touch will provide insight on how effective healthcare could best be delivered by establishing a strong patient-physician relationship.

In a nation of expensive healthcare with a shortage of physicians, the results of this study may help physicians understand the barriers and solutions to building a trusting relationship with their patients. This study looks to provide more information for an ideal patient-doctor relationship and how physicians can use interpersonal skills along with physical touch to establish rapport with patients. This study also is significant in clearing up the contrasting priorities between physicians and their patients in regards to how healthcare should be delivered.

Chapter 2: Survey of Literature

With the rise of technology in modern medicine, it only makes sense that doctors utilize cutting-edge technology in order to provide the most optimal healthcare for their patients, and also to increase efficiency for themselves. However, effective communication, otherwise known as a doctor's "bedside manner," may also be hindered by the technology that is supposedly optimizing healthcare. Considering the ways we describe healthcare delivery, the vocabulary we use is problematic on its own. For example, the word "optimize" insinuates improving a process that sounds more economic than humanistic. The word seems to imply that we are striving to improve results, rather than focusing on the people involved. I would argue that the problem lies more with communication abilities of the people rather than the machines. In order to define effective communication, Dr. Christy L. Cummings summarizes the concept well:

"Our patients deserve our undivided attention, especially given the limited time we have during each encounter. Effective communication also involves demonstration and verbalization of understanding after listening, often by summarizing or repeating what has been conveyed, and a reciprocal exchange of information between those involved. Finally effective communication requires an environment with minimal distraction. This ideally results in a trusting physician-patient relationship, an equal exchange of information between all parties, and shared decision-making," (Cummings, 2013).

Dr. Cummings mentions key concepts involved with effective communication, such as, "undivided attention," "a reciprocal exchange of information between those involved," and "an environment with minimal distraction." She also emphasizes the concepts of listening and then being able to verbalize understanding as a sign of affirmation. She applauds the incorporation of technology into our healthcare system today, and is by no means suggesting that we revert to a time without technology. Like Dr. Cummings, I propose that physicians should be more conscious when using technology, as it has significant potential to disrupt the patient-physician relationship by obstructing means of communication, both literally and metaphorically. The

physician should prioritize effective communication – being present and actively listening to the patient. As Cummings describes, large computers or machines may literally obstruct the ability for a doctor and patient to be able to communicate effectively with eye contact. Additionally, the obstruction caused by a machine diminishes the potential development of a trusting relationship if the body cannot be seen. A classic body language cue that signifies secrecy or failure to connect is a body hidden behind an object (Navarro & Karlins, 2008). Not all machines that physicians use in the office are large and obstructive. It is not uncommon to see a doctor carrying a mobile electronic tablet that may fit more easily into a pocket. Despite the removal of the physical obstruction, one concept of effective communication that Dr. Cummings defines is still violated. For example, the doctor may quickly jot down a progress note while visiting a patient, but this means the doctor is not giving his/her undivided attention even though he/she may still be listening. Yet again, it is important to understand technology's role in the healthcare, as it is still effective and necessary. The physician should use technology to supplement the treatment process but prioritize the cultivation of the patient-physician relationship.

The concept of effective communication goes further than simply building a stronger and more trusting relationship with the patient. In an article by Ha, Anat, and Longnecker in 2010, effective communication serves to benefit both the physician and the patient (Ha, Anat, & Longnecker, 2010). For patients, they have a stronger understanding of their condition, prognosis, treatment plan, and ultimately are provided with all of the information required to make informed decisions about their health. As a result, patients are more likely to trust their doctor, leading them to be more compliant, adhere to treatment plans, and follow up with their doctor more frequently (Bartlett, et al., 1984). According to Bartlett, et al., patients are much happier when they feel that their doctor is actually listening to them, as opposed to dominating

the conversation. On the other side, the benefits of effective communication relate to the physician in complementary ways. When the patient is happier and compliant, then treatment plans have a higher success rate, minimizing conflict and stress between doctor and patient. For the physician, these effects ultimately result in a stronger relationship with their patients, yielding higher job satisfaction. Focusing on overall patient health outcomes, Cummings explains, "[g]ood communication also improves certain patient health outcomes, such as emotional health, symptom resolution, function, pain control, and even physiologic measures like blood pressure or blood sugar" (Cummings, 2013). These conclusions were carried out through standardized observations along with quantitative and qualitative surveys.

Although it is important to discuss how doctors can practice more effective communication skills, communication complications are prevalent when there is a lack of mutuality between doctor and patient. In a cross-sectional secondary analysis, a group of doctors and their patients were asked to fill out surveys to assess the communication skills of the physician throughout their interaction (Kenny, et al., 2010). It was found that the scores lacked congruency between doctors' scores and patients' scores at a statistically significant level. This data indicates that there is a discrepancy between doctors' and patients' interpretations of how well the doctors communicate. A significant factor that contributes to this discrepancy is bias. As Dr. Danielle Ofri writes in her book, *What Doctors Say, What Patients Hear*, physicians often do not value the "less-tangible components of medicine—communication, connection, and empathy" (Ofri, 2017). There seems to be an inherent bias from doctors, where they fixate on following protocols. If a patient is resistant or non-compliant, this may warrant frustration from the physician, who may assume that the patient is being unreasonable. This bias is one basis for a paternalistic model of medicine. While this may not hold true for all cases, this is an important

factor to consider when refining communication skills between the patient and doctor. Due to the subjective nature of effective communication, a higher degree of social and emotional intelligence is required for physicians to interpret their patients' behaviors and responses during each interaction.

Furthermore, incongruence translates to the power difference between the physician and patient. This predisposition comes with the implicit roles of the physician and patient. The physician is the expert, and the patient usually seeks assistance, giving rise to the paternalistic model of medicine. This model of medicine implies that the patient lacks the capacity to understand complex medical information and to make decisions about their health care. Therefore, the physician would need to make the decisions for the patient, much like how a parent would make decisions for the child. Additionally, the attire of the physician and patient also has hierarchical implications, historically (Wellberry & Chan, 2014). The physician's white coat signifies a professional status, while the patient's gown symbolizes undressing as the "stripping of the wearer's identity," yielding vulnerability from the patient's perspective.

The emotional awareness required for doctors helps physicians create a more welcoming and comfortable environment for their patients, as a way of showing respect to the patient's surrendered vulnerability. Something as simple as a handshake to greet the patient helps break down the initial barrier of discomfort when meeting for the first time. This initial physical contact is a common initiator, along with appropriate communication skills, and allows the physician to easily move towards a physical examination. The idea of physical touch has the power of creating a closer connection to the patient, both literally and metaphorically. Human touch is something that can never be replicated with machines, and the influence of such touch psychologically aids in treating the patient.

"The quality of health care depends not only on how well physicians and other health professionals perform their tasks and the reliability of the technologies they use, but also on their ability to be human. To touch and be touched is part of the process of staying well or getting well" (Bruhn, 1978).

As a pre-medical student, there are two options in degrees that lead to become a practicing medical physician. The allopathic route is the more traditional route that awards a doctorate in medicine (MD), and the osteopathic route is a newer method, awarding a doctorate in osteopathic medicine (DO). Osteopathic physicians are unique in the sense that they are equipped with the ability to use osteopathic manipulation techniques, which employ physical manipulations of the body to treat disease and dysfunction. As Dr. Brian Degenhardt mentions, "[t]herapeutic touch has the ability to soothe and comfort patients, affecting them on physical, emotional and spiritual levels" (Degenhardt, 2000). Physical touch insinuates the notions of warmth, healing, and empathy. If the physician is able to establish a routine, or ritual, where physical exams and manipulative techniques are perceived as means to healing, then the patient will associate this with positive expectations, therefore strengthening the trust and efficacy of treatment (Benedetti, 2010). To combine the aspects of physical touch and effective communication, it has been shown that "caring and warm patient–practitioner interactions can enhance the therapeutic value of clinical encounters when patients' positive expectancies are actively encouraged and engaged" (Maxie, et al., 2018).

While an analysis of primary literature has revealed the significance of utilizing effective interpersonal communication skills, it tends to only discuss communication skills from the doctor, rather than the patient. In addition, the literature shows a scarcity of research regarding how doctors employ physical touch to better establish the patient-physician relationship, and

how that ultimately affects patient responses and health outcomes. In my interviews with various physicians, these questions will be explored further.

Chapter 3: Physician Interviews

The patient-physician relationship is a unique one that is delicate, and requires compassion and empathy from both parties. Through the exploration of effective interpersonal communication and physical touch in primary literature, we can see that while technology is certainly an advantage, it is also a distraction. To further understand the role of physical touch and effective communication from the doctor's perspective, I interviewed ten doctors, who will be identified as Doctor A-J. I asked each doctor a variety of questions in order to ascertain their routines and viewpoints in providing the most welcoming and trusting environment for their patients.

I. Personalities of Care

I began by asking each doctor about how they would characterize the patient-physician relationship and relate this to what they do as physicians to create the best possible in-office experience for their patients. The objective of this portion of the interview was to identify each doctor's style of providing care. As mentioned before, the patient-physician relationship is a unique one, and the personalities of each person are significant factors in how the relationship develops. Additionally, this part of the interview gave more insight into each doctor's values when providing care, aside from the obvious goal of treating the patient. Despite different styles of care, common themes arose when each doctor discussed their relationships with patients. When asked about how they would characterize the patient-physician relationship, every doctor highlighted the common themes of trust and open communication.

"To me, [the patient-physician relationship] is the core of medicine. I agree with you and Verghese in that most of what you need to know about the patient - you can get from the history, and from talking to them, and establishing that sense of trust. The whole medical profession is based on trust, and the patient is willing to extend that to you and trust you initially, but if it is violated in any way, then you can almost never get it back. It's the key part of the relationship." - Dr. D

"I'd see it as a very collaborative interaction. [...] The first rule of medicine is to first do no harm, and I think that by doing that, you need to get full consent from the patient, so that they really understand your course of treatment, since some [treatments] can get pretty invasive. If you can't explain [the procedures] in a way that is clear to them, then you should get a better understanding yourself. [...] It's very much more of a 'we're on the same team' mentality.'" - Dr. H

Both Dr. D and Dr. H discuss the ideas of trust and teamwork when defining the patient-physician relationship. In different ways, both doctors discussed how open communication helps develop trust between both parties, which seems to be the essential underlying foundation of providing the best quality of care for the patient. Dr. D explains using effective and clear communication when first meeting the patient, while Dr. H explains the communication skills necessary to clearly communicate treatments to the patient since the physician is the one administering the treatment. Additionally, Dr. J stated that "[trust] represents the vulnerability on the part of the patient." Both Dr. D's and Dr. H's explanations connect to the concept of vulnerability because patients come to doctors for medical advice and treatment. This interaction will always be predisposed to an "inherent power differential," as described by Dr. J. The simple fact of the matter is that the doctor is expected to be more knowledgeable about health and medicine relative to the patient; this is the reason why doctors and other experts exist. Therefore, establishing trust between patient and physician sets the stage for enhanced cooperation, mitigating the power difference.

In order to mitigate this power difference, Dr. G's approach relies on humor. Dr. G describes an approach to dealing with the patient in his own proposed model of relationships

with patients, known as the "jester model." This model posits that the court jester of old times was not only an entertainer, but also a teacher to the king and queen, which conversely creates a new sense of vulnerability in the position of the jester, or physician. The jester serves to aid the king and queen by expanding their knowledge primarily through the means of entertainment, but also to ease any discomfort for the monarchs. However, the jester is also at risk of losing their status and reputation, where the monarch holds the power. In terms of medicine, we can consider the court to be the exam room, with the patient, or the monarch, sitting on their throne (the exam table), literally elevating them above that of the physician, or the jester. In this model, the physician is the educator as well as the source of relief for the patient, guiding them and treating their ailments. Yet, the physician also has a reputation or status to uphold, driving the necessity to provide effective care and meet the patient's expectations. This model alludes to Dr. G's approach of connecting with the patient through the usage of humor and entertainment to ease their discomfort, but also demonstrates the mutuality of vulnerability for both parties.

II. Preparation

Another interesting theme that arose among doctors' responses is the concept of preparedness. In Dr. J's daily routine, he prepares for the patients that he sees the following day by taking time to sit down and read through their medical histories. With my other interviewees, the focus relied more on being aware of the patient's chief complaint before meeting with them, understanding what has been already done for them to mitigate redundancy, and also to be mentally prepared to listen. Dr. F mentioned the stress of time and seeing so many patients in a day that it can be easy to lose focus on the task of the moment. Referring back to Dr. Cummings's article, she emphasized the importance of "undivided attention," "a reciprocal exchange of information between those involved," and "an environment with minimal

distraction." Each emphasized some variation of the notion of "being in the moment." This implies leaving all distractions, thoughts about the past and future outside of the exam room, and to give the patient the undivided attention that they deserve. For the physician, this requires a high level of discipline.

The complexity of using effective communication seems to be a significant challenge that doctors deal with on a daily basis on top of the medical challenges that they face. I wanted to better understand how each physician developed his or her skills in communication, and more specifically, how they learned to communicate effectively with their patients. Was there coursework, or did they solely learn on the job? Dr. G explains:

"Historically, no, I did not [have formal training with communication]. What I had were mentors - other people that I could watch, see, and emulate. I was very lucky in my training that I had six weeks where I would go out into a far-away place and spend some time with a physician, and learn, which is very different from the current medical student experience. I went over to Ontario, Oregon and spent six weeks with Dr. Daniels, who was a family doctor over there. He got to teach me what I needed to know about interacting with patients - what mattered, and what didn't. But I didn't have anything formal. There is more formal training now, but back in the day, they didn't have that." - *Dr. G*

Dr. G's experience explains a mentorship model, where young doctors learn about how to interact with patients primarily through observation of a more experienced doctor. With this model, there is an implication that older physicians would theoretically be the more personable and effective medical experts based on the greater amount of experience. However, while observation is one way to learn about interacting with patients, Dr. J explains that, "just observing something doesn't make you an expert at it. Expertise comes with practice and actually doing." Dr. J's perspective appears consistent with the shift in contemporary medical education that focuses more on the humanitarian side of medicine. This can be seen with the

new, longer format of the Medical College Admissions Test (MCAT), dedicating an extra ninety-five minutes to the social sciences alone. Also, changes in medical school training have been implemented, as Dr. H explains his experience:

"In medical school, there's a huge push right now to make physicians more approachable. [...] At the end of your third year, they make you do standardized patient encounters, where you have six, or eight, or however many patients, and you have about twelve minutes to go talk with them, figure out what's going on, what they're there for, and then write a note about what you think is happening with the differential. It's stressful, but what they're really looking for is: can you empathize with the patient who is going through a difficult time? Can you break bad news to people? Can you perform a physical on them in a way that makes them feel that things are going to be okay? I can see the need for [this exam] for sure." - Dr. H

Obviously, Dr. H's experiences in medical training differ greatly from those of Dr. G's. The shift in emphasis indicates society's increasing value for having personable doctors. When postulating the significance of having more personable doctors, a connection can be made to the inherent power differential between doctor and patient as previously explained. According to a number of the interviewees, mitigating this power differential is the first step in being able to establish an effective and trusting relationship with the patient. Interestingly, there does not seem to be one definite way to acquire such interpersonal skills. Many of the interviewees acquired these skills through observation and experience. While this may be successful, it makes a young doctor's skill set dependent on the teaching ability of their mentors along with the types of experiences they may encounter. Conversely, we see a change in current medical school systems requiring pre-medical students to learn these skills prior to attending medical school through the social science addition to the MCAT and situational testing incorporated into medical school curricula. Overall, the current expectations for pre-medical students appear to incorporate independent learning of communication and compassion through volunteering, clinical experiences, and leadership experiences. Students then receive reinforcement of these skills in medical school

through simulated patient interactions, thus showing how young doctors acquire these interpersonal skills.

III. Showing Care

Focusing more on the component of communication, I have primarily discussed the ways in which a physician can actively communicate more effectively in order to establish a stronger relationship with their patients. However, it is important to remember that communication may be defined as the exchange of information (Cummings, 2013). While I have discussed various active steps in communicating, the physician must also be able to passively communicate through listening. To reiterate, many of the interviewed doctors expressed the importance of being present when communicating with their patients. A crucial aspect of this is the ability to listen, understand, and provide care in such a way that reflects and addresses the patient's thoughts, opinions, and concerns.

"I will have patients that almost always expect a physical exam. I can even tell you about a patient I had recently seen where the first time I saw her, I did not examine her feet because that was not the main problem at hand, but she was very upset that I didn't examine her feet. So, the next time, I made very certain to examine her feet the next time I saw her, and explicitly said, 'let's examine your feet today' to make her very happy, so that made her feel really happy and really develop that sense of trust." - *Dr. C*

In this instance, Dr. C explains a time where she effectively listened to her patient in order to establish a trusting relationship. One may perceive this example to be quite small and insignificant, but let us consider what may have happened if Dr. C had forgotten, or did not listen to her patient, and failed to examine her feet. As mentioned, the patient was visibly upset about the matter, therefore suggesting that this matter was truly an important matter to her, regardless of whether or not it had medical significance. If Dr. C had neglected to complete the patient's

request, then the patient may conclude that Dr. C did not listen to her, and is therefore not concerned for her health. The conflict could lead to complications in patient health outcomes, resulting from noncompliance and distrust (Bartlett, 1984).

In addition to compassion, a physician's primary role is to heal, or provide effective healthcare. A part of providing effective care is the ability to fulfil the expectations of the patient. Of course, this is a contextually-dependent type of fulfillment. As my interviewees seemed to agree, a patient will almost always appreciate that the doctor has done everything in their power to try to heal the patient, regardless of the outcome. However, it is important to remember that the physician's objective is not simply to appease the patient. The concept of meeting the patient's expectations is meant to be one aspect of building trust and ultimately leads to more effective healthcare delivery.

"I touched every patient. [The physical examination] does a lot of things. It tells you where you need to apply your technology, and where you don't need to apply your technology. I think that every person deserves some kind of physical touch. Now, when following a patient with chronic disease, it's not going to matter in a clinical sense whether I examine them or not. If I was seeing a patient with lung disease and I was almost certain that I wouldn't detect any changes, I would still listen to their chest. Part of it is acting, part of it fulfilling a role, and part of it is meeting expectations." - Dr. D

Dr. D states that when he practiced, he always tried to touch every patient, even if it was only a handshake. He asserts that "all patients deserve to be touched," as it is essential in establishing trust and breaking down barriers between the patient and physician. Similar to Dr. C, Dr. D believes in performing physical examinations despite the lack of clinical significance. As he states, "part of it is acting, part of it fulfilling a role, and part of it is meeting expectations." Dr. D's justification for performing a physical exam at all costs relates to how Dr. Abraham Verghese discusses the significance of the exam. As Verghese mentions, the physical exam is a

ritual; its implication involves the threshold of crossing, where a doctor and patient become human and human. The physical exam also connotes the notion of healing, which serves to at least begin fulfilling the patient's expectations of the doctor, but to also establish a connection with the patient. I found it interesting that Dr. D referred to this as "acting," almost as if there is an implication of deception. However, I would not interpret this usage of a physical examination in that way. Dr. C's anecdote regarding her patient's feet serves as an excellent piece of evidence which justifies this "acting." The purpose of performing this "clinically-useless" exam is to provide comfort and assurance for the patient. To reiterate, the role of the physician is to heal and relieve the patient from suffering. A physical exam may seamlessly build rapport with the patient, and serves as a tangible, objective benchmark to begin the process of healing.

IV. Barriers

After discussing the expectations of care from the patient and physician perspective, it becomes apparent that delivering these expectations is not always so simple. In a world that demands quality healthcare with a shortage of doctors, barriers in properly developing the patient-physician relationship affect the delivery of healthcare today. A common barrier mentioned by every physician is time. All it takes is one person to either arrive late, or if the appointment goes over by just a few minutes to put the physician off their schedule. For a doctor with a tight schedule, every minute counts. In these cases, the ability to communicate efficiently, as well as effectively, proves to be paramount. "When you're rushing, and just want to get out of there, they [the patients] know; they can tell," Dr. E explains. As a professional, punctuality should be a priority, especially when looking to establish a healthy first impression. However, this may not always be possible due to the previously mentioned reasons. The time barrier not

only complicates the development of the patient-physician relationship, but also may be a detrimental stressor.

Another common barrier that the interviewees discussed is burnout. With the stress induced by time, high work pace, and conflicts with patients, stress has a significant role in inhibiting effective healthcare delivery. Studies have shown that poor patient-physician relationships are related to low job satisfaction, and ultimately result in job burnout for doctors (Ha & Longnecker 2010). Therefore, doctors should understand strategies in how to mitigate these common barriers in healthcare.

"In primary care, it's very challenging. I have to be very clear about the time we have available for that encounter. And for me, this is where hands-on touch is really important because even if I can't get to items number five through ten of someone's concerns, I was at least there and able to look them in the eye, and put my hands on them. I feel that at least my patients can walk away knowing that I did my best to try to hear them and address what I could."- Dr. C

"The barrier would be if you feel like you don't have enough time to address this whole event. You may need to reschedule the event, and let them know that you want to see them again." - Dr. B

For each doctor, we can see different strategies for mitigating the time barrier. With Dr. C, the usage of physical touch along with listening skills expresses empathy and compassion so that the patient will perceive benefit from the interaction, despite not being able to address every concern that they originally had. With Dr. B, the usage of clear communication establishes the problem of lacking time, but also indicates a proactive desire to continue the discussion. This strategy cuts the patient short, but mitigates the feelings of abandonment by proactively scheduling a time to continue the conversation in the future.

However, Drs. C and F described resorting to a more paternalistic approach as a last resort. For example, if a patient has a reputation of having an excessive amount of topics to

discuss, then Dr. C and Dr. F would address the time constraint proactively by reminding the patient of their time constraint. This method is not preferred, as the patient is likely to perceive that as a warning, or a message with a negative connotation. By mitigating the time constraint, more time may be spent with the patient, allowing for a thorough development of a trusting relationship. Therefore, mitigating time seems to indirectly contribute to mitigating the stress barrier as well.

When dealing with a difficult patient, it may be easy for the doctor to become frustrated and diminish their compassion. The interviewees typically identified a difficult patient to be someone who is usually noncompliant, or misinformed, giving rise to conflict and the doubting of the doctor's treatment methods. The common lesson present among the physicians is to keep calm in these situations; the goal is to be informative, respectful, and open-minded. Each doctor explained an instance of how they dealt with a difficult patient, where each doctor found themselves taking a step back, and simply being informative. They acknowledge that they cannot forcefully impose a treatment on anyone, and ultimately, it should be the patient's responsibility in regards to how they manage their bodies. The role of the physician in this case is to clearly communicate the risks and benefits of their decision, and to provide clarity to any misconceptions they may have. While the patient may ultimately disagree regardless, the doctor's objective is to maintain a level of respect and professionalism between patient and physician.

Chapter 4: Conclusions & Limitations

To reiterate, this work looks to explore the questions: (1) How are interpersonal communication skills and physical touch essential to an effective patient-physician relationship? (2) How can these skills be best utilized to provide for better delivery of health care?

To revisit Dr. Abraham Verghese's talk, expressing compassion, being present in communication, and human touch are essential in providing truly effective healthcare. As technological advances arise at astounding rates, the human aspect of medicine becomes increasingly vital. Through a study of primary literature and physician interviews, this work explained the roles of interpersonal communication skills and physical touch on the development of the patient-physician relationship. Physician interviews offered unique strategies in how doctors utilize their interpersonal communication skills to improve the way they provide care and establish rapport with the patient. The study of these elements showed variability in approaches of establishing a trusting relationship through the usage of effective communication and touch. Each physician contributed unique perspectives, but many commonalities may be observed in their approaches.

The first step in developing trust is to ease the discomfort and mitigate the inherent power difference between doctor and patient. Despite this power differential, Dr. G's jester analogy demonstrates a neutralizing perspective, where the physician is susceptible to vulnerability as well when considering their reputation and fulfilling the patient's expectations. Considering the patient's perspective, they visit the physician with implicit vulnerability as they must metaphorically and literally expose themselves to the doctor, relying on the physician's expertise for treatment. With mutual vulnerability expressed between both parties, effective communication and physical touch serve as the bridge of trust between healer and patient.

Examples of effective communication include clarity of treatment method and actively listening. The interviewees expressed the importance of being prepared to see the patient by obtaining a good history and understanding their concerns and desires. As the expert, doctors should be able to explain diagnoses, prognoses, and treatments clearly enough for their patient to understand, but to also show that they are addressing the patient's concerns and making them feel that they are included in the decision-making process. Both the literature and interviews suggest that effective communication skills are essential in establishing trust and building a positive relationship with the patient. Then, this inherently yields positive patient health outcomes, and mitigates the barriers of time, stress, and burnout for the physician.

Though there is a necessity for utilizing effective communication, there are times when physicians may feel that they do all the appropriate things, but the patient does not perceive the same. Dr. Ofri's book describes this discrepancy by mentioning an inherent bias from physicians. Much like the paternalistic model, there seems to be a bias among physicians that the physician knows best and that the patient should be compliant in order for effective care to be delivered. Ofri's book demonstrates this bias well, as she discusses situations in which physicians become frustrated with patients who behave differently than what a doctor would hope for. Erratic patient behavior and failure to initially empathize clearly show the accumulation of distrust and tension between provider and patient. She posits that this communication discrepancy may be resolved through patience and truly listening to the patient. Therefore, like Cummings also asserts, being in the moment and verbalizing understanding are direct ways in which the doctor may assure that they are truly communicating with their patients.

Lastly, the role of physical touch played a significant role in supporting effective communication. Whether the touch came from a handshake or a physical exam, the initial human

touch signifies empathy and serves to initiate a connection between doctor and patient. As for the role of the physical examination, I found it interesting that exams would always be performed if requested, or in a ritualistic manner, symbolizing the transformation of doctor and patient into human and human. This transformation serves as an equalizer and allows for a literal and metaphorical connection between both parties. A physical examination may not be necessary when no clinically significant findings are expected, but in these cases, it serves to fulfill an expectation from the patient that the doctor seeks to heal them.

The limitations of this study include a small sample size of interviewed physicians as well as inadequate research on the effects of using physical touch in medicine. The small sample size of doctors allowed for personalities to become a bias, as well as the role of the medical specialty. Another significant limitation of this study is the lack of perception from the patient perspective. This study could be strengthened by ascertaining what patients value in the patient-physician relationship. Additionally, understanding what patients believe regarding how interpersonal communication and physical touch impact the quality of care would be useful in furthering this study.

Through this work, the understanding of the doctor's perspective of the patient-physician relationship has been strengthened, fixating on the role of interpersonal communication and physical touch. As previously mentioned, understanding the patient's perspective would be the next step in truly understanding how these two elements affect the relationship. Ultimately, this would allow us to gain a better grasp on the humanistic side of medicine. To build on the notion of effective communication, discussing the ideas of accessibility and accommodation from the physician would also provide more insight. Also, further studying the discrepancy between how doctor and patient perceive the quality of care is a necessary step. While doctors are now being

taught to focus more on interpersonal skills, it would be necessary to understand how doctors develop their emotional intelligence. This emotional intelligence entails the ability to not only follow the rules of effective communication, but more importantly, to also be able to notice and respond to cues provided by the patient – both verbal and nonverbal. Verghese describes the body as a "text." As physicians, or simply humans, everyone learns to read and interpret texts in different ways. Therefore, the ability to interpret "text" would be significant in complementing this body of work.

Final Thoughts

Throughout this study, I was allowed the opportunity to speak to many health professionals many years of experience. Aside from learning the significance of interpersonal communication skills and physical touch, I learned the importance of simply being human and relatable. As an aspiring physician, I hope to join a league of highly knowledgeable individuals equipped to save lives with vast technical knowledge. However, this status should not take away from the idea of being human. This project has been a humbling experience that has allowed me to further understand some of the most crucial, but subtle aspects of healing. Being present in conversation and empathizing with someone are some simple ways to establish trust and rapport. My initial objective in this project was to learn how to be a better doctor, but I have come to realize that these factors of trust create not only a better doctor, but a better human being.

Bibliography

Bartlett, E. E., Grayson, M., Barker, R., Levine, D. M., Golden, A., & Libber, S. (1984). The effects of physician communications skills on patient satisfaction; recall, and adherence. *Journal of Chronic Diseases*, *37*(9–10), 755–764.

Benedetti, F. (2010). Patient's brain : The neuroscience behind the doctor-patient relationship. Retrieved from https://ebookcentral.proquest.com

Bruhn, J. G. (1978). The doctor's touch: tactile communication in the doctor-patient relationship. *Southern Medical Journal*, *71*(12), 1469–1473.

Clement, D., & Cohn, J. (1999). Salvaging the History, Physical Examination and Doctor-Patient Relationship in a Technological Cardiology Environment. *Journal of the American College of Cardiology*, *33*(3), 892–893.

Cummings, C. L. (2013). Communication in the Era of COWs: Technology and the Physician–Patient–Parent Relationship. *Pediatrics*, *131*(3), 401–403.

Degenhardt, B. Osteopathic Manipulative Medicine - Optimizing Patient-focused Health Care. (2000). Retrieved December 21, 2018, from https://www.aacom.org/become-a-doctor/about-om/degenhardt#

Gáspárik, A. I., Ábrám, Z., Ceana, D., Sebesi, S., Fărcaş, D., & Gáspárik, A. C. (2014). Shortages of Doctor-Patient Communication. Teaching Patients to Communicate Effectively. *Procedia - Social and Behavioral Sciences*, *142*, 376–379.

Ha, J. F., & Longnecker, N. (2010). Doctor-Patient Communication: A Review. *The Ochsner Journal*, *10*(1), 38–43.

Kenny, D. A., Veldhuijzen, W., Weijden, T. van der, LeBlanc, A., Lockyer, J., Légaré, F., & Campbell, C. (2010). Interpersonal perception in the context of doctor–patient relationships:

A dyadic analysis of doctor–patient communication. *Social Science & Medicine*, *70*(5), 763–768.

Maxie, B., Nathalie, P., Thelma, W., & Luana, C. (2018). The Role of Patient–Practitioner Relationships in Placebo and Nocebo Phenomena. International Review of Neurobiology, 139, 211–231. https://doi.org/10.1016/bs.irn.2018.07.033

Navarro, J., & Karlins, M. (2008). *What every BODY is saying: An ex-FBI agent's guide to speed reading people.* New York, NY: HarperCollins.

Ofri, D. (2017). *What Patients Say, What Doctors Hear*. Boston, MA: Beacon Press.

Verghese, A. (2011, July). A doctor's touch. Retrieved from https://www.ted.com/talks/abraham_verghese_a_doctor_s_touch?language=en

Wellbery, C., & Chan, M. (2014). White coat, patient gown. Medical Humanities, 40(2), 90–96. https://doi.org/10.1136/medhum-2013-010463