Communicator: The Gynecologist Who Could Not Convince His Patients

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26.1 Introduction

The first meeting with a patient is usually devoted to identifying the patient’s health problem or healthcare needs. The biopsychosocial (BPS) model works with a broad definition of “the problem.” The gynecologist, midwife, etc.—for the sake of brevity, from this point on, we will use the term “health professional”—try to gain as complete as possible a picture of the reason why the patient has come, the medical problem (diagnosis), and any additional problems or issues the patient may have, whether they are physical, mental, or social. In other words, the health professional not only pays attention to the physical manifestations of a complaint but also assesses the patient’s care request. On the basis of this assessment, the health professional maps out the mental and social components, causes, and consequences of the problem. In this chapter, we will focus exclusively on the educational information and guidance you give your patients in this context.
Health professionals in the Western world give their patients a great deal of information\(^1\); they have a duty to adequately inform their patients about the state of their health, tests, the prognosis, the treatment options, etc. In most cases, this information is given to individual patients during a consultation at a surgery, a home visit, or a ward round, which is why the tips in this chapter are mainly about the information given to patients face to face in clinical practice. However, they can also be used in situations in which you provide information by telephone, e-mail, or online.

As discussed in Chap. 22, working according to the BPS model means examining complaints both in depth and in breadth. The health professional not only looks for a solution to the medical problem but also pays attention to the problems that arise from it and to the patient’s psychological and social needs. This requires a broad definition of educational information for patients, such as Van den Borne’s [1]:

“The use of educational methods, such as the provision of information, advice and behavior modification techniques, to influence the patient’s knowledge, opinions, and health and illness behavior in order to ensure that the patient is able to co-operate effectively in deciding on the care which he receives and can make the best possible contribution to that care”.

On the basis of this definition, a health professional may have several complementary goals in mind when providing educational information:

1. To help the patient understand the nature and consequences of his or her disorder, which additional tests may be useful, and what the treatment options are
2. To create an action plan in consultation with the patient
3. To reach agreements with the patient regarding the execution of this action plan (informed consent)
4. To support the patient with their role in the action plan, for instance, in regard to taking medication, doing exercises, or making lifestyle changes
5. To evaluate the action plan and if necessary to modify it, in consultation with the patient

In addition to these “primary goals,” a consultation usually has secondary goals, which may also change during the consultation, depending on the health professional’s insights or the patient’s reactions. For instance, it may become clear during a consultation that a patient is quite worried about her disorder, in which case the most important thing is to reassure the patient as much as possible before discussing a plan of action. Or the patient may have already found a lot of information about her disorder online, but it may turn out this information is not all correct. In that case, you will need to correct the patient’s inaccurate ideas before you can proceed

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\(^1\)This manual concerns only the patient as a discussion partner. In clinical practice, especially if using the BPS model, a health professional will also have other discussion partners such as a patient’s family members or other health professionals involved in a patient’s care. To keep things simple, we will not continually refer to these other discussion partners.
to discussing the best approach. Or it may turn out that a patient cannot or is unwilling to follow your recommendations. In that case, you will have to discuss this “treatment noncompliance” with the patient if you want to be sure the agreed treatment is actually going to be effective. It should be clear that as a health professional, if you want to achieve the goals listed above, you will need to have conversational skills that go beyond being able to explain things well. The CELI model, discussed in the next section, divides these conversational skills into four sub-competences:

- Control and rapport
- Explaining
- Listening
- Influencing

However, before going into further detail, we will take a look at a number of consultation situations. Because giving educational information covers such a wide range of areas, this time we will follow a gynecologist in several different situations involving patient education.

**Case History: Ms. Mustard**
Dr. Garry White, a gynecologist working at a medium-sized hospital in the north of the Netherlands, has just performed an ultrasound scan on Ms. Mustard, a 29-year-old patient who is now 16 weeks pregnant. The scan shows a healthy fetus, and Dr. White congratulates his patient on the successful development of her pregnancy. He then casually asks her about her smoking and drinking. In one of the previous consultations, he had already asked her about her use of these substances, and she had told him that she was still smoking quite a lot and regularly having a glass of wine. At that point, Dr. White had given Ms. Mustard detailed information about the detrimental effects this would have on her baby’s development, and he is now interested to hear whether she has heeded his advice. However, he realizes that his question has not gone down well at all.

Whereas she had talked quite openly about how the pregnancy was going, she is now clearly reluctant to answer this question. Yes, she is still smoking and still regularly drinks a glass of wine, but it’s very difficult to stop given all the stress and changes in her life.

For a moment Dr. White considers explaining to her again how harmful her behavior is for her unborn child but decides not to do so, because he doesn’t want to make the atmosphere even worse. Dispirited, he thinks to himself: “I explained it to her so clearly, but apparently she just doesn’t want to understand what her unhealthy habits are doing to her baby. Oh well, it’s her choice.”
The CELI Model

To attain the educational goals listed earlier, the health professional must not only give the patient information but also help the patient to comprehend and assimilate this information and on the basis of the information to make a carefully considered decision about the required healthcare [2]. Then the health professional should help the patient to adapt her behavior and lifestyle accordingly. In doing this, the health professional must take into account the psychological processes that take place within the patient when this information is given. These processes are shown in the inner oval of Fig. 26.1 [2]:

- Being attentive and receptive
- Comprehend and store the information (cognitive level)
- Evaluate and digest (emotional level)
- Making decisions and adapting behavior (behavioral level)

The CELI model, which is derived from the Yale persuasion model [3], differentiates the communicative tasks a health professional must perform to ensure that the psychological processes listed above run smoothly. These tasks or sub-competences—control, explaining, listening, and influencing—are shown in the outer oval of Fig. 26.1 [2]. The following sections provide further clarification of these sub-competences. In the section titled Tips and Tricks in this chapter, an overview is
given of the patient education skills that go with these sub-competences. The limited scope of this chapter does not allow us to discuss all patient education skills in detail; we will examine only those aspects of patient education that are of particular importance to health professionals who work according to the BPS model.

26.2.1 Control and Rapport

Case History: Ms. Mustard Revisited

Even though it takes great effort, Dr. White asks Ms. Mustard to sit down again. “Sorry, I forgot something,” he says.

Ms. Mustard sits down again, a bit surprised, but because of this Garry knows he has her full attention. “Last time we talked about things like smoking and drinking. I had the impression that that didn’t really help you and I’d like to do something about that. I want you to know that in the first place my job is to care for you, regardless of what you do or don’t do. At all times—even when you do things I’m personally not happy about. OK?”

Ms. Mustard looks at him with relief. “I’m glad to hear that, doctor, because the last time I felt just like a little girl being put in the naughty corner. And of course I know I should really stop smoking and drinking, but I just don’t see how I can do it.”

In the first instance, Garry feels inclined to talk to her about the importance of a healthy lifestyle for her unborn child. Fortunately he realizes just in time that this would be more of the same and would therefore be counterproductive. “People always act as though it’s easy, but I think that right now it might be harder than ever to break certain habits that actually give you a kind of support.”

Ms. Mustard nods and immediately agrees with him. “Exactly doctor, you do it almost without thinking about it. But if I don’t light up a cigarette, it’s as though the whole world is coming at me.”

Garry now agrees with what she has said. “OK, so on the one hand it’s extremely difficult to break habits like these, and on the other hand, we agree that you really should stop or at least smoke and drink as little as possible.”

Ms. Mustard nods and shows that she has more self-knowledge than he had thought. “Perhaps I should talk to someone about the panic I suddenly feel sometimes, it’s really not normal….”

26.2.1 Control and Rapport

Case History: Ms. Peach

“But doctor, it must be something. That pain comes back all the time!”

“Well, Ms. Peach, I don’t think there’s anything wrong. I couldn’t feel anything abnormal during the internal examination, your blood test was OK, there were no abnormalities in your urine or feces, and there was nothing unusual in the ultrasound scan either. Everything looks fine. I think you
Information can only sink in if the patient is ready and able to listen to the information and be open to it. The most important prerequisites for this are:

- The patient is aware of and agrees with the goals of the consultation.
- The patient’s attention is not distracted during the consultation by external stimuli.
- The patient’s emotions will not prevent them from taking in and processing the information.
- The patient feels at ease—as much as possible—during the consultation and has confidence in you.

To a large extent, these prerequisites will be met if you stay in control of the conversational flow and also make sure you have good rapport with the patient. Appropriate use of the other sub-competences will also have a positive effect on your control of the conversation and your rapport with the patient. It is important to be a good host in the contact with your patient; a medical consultation is not an ordinary conversation; it is a meeting with preset goals, and the health professional is primarily responsible for the attainment of these goals. The health professional must therefore control the conversational flow. However, control does not mean that the patient is a passive contributor to the consultation. On the contrary, good control entails the health professional inviting the patient to actively participate in the conversation [4]. The control task relates to three aspects of the consultation: (1) control over the situation to ensure the conversation is undisturbed and private; in Fig. 26.1, this control task is positioned outside the consultation oval since this task must be performed before the consultation starts; (2) guiding the conversation in order to reach the preset goals [5, 6]; and (3) fostering the relationship [4, 7]. Control includes activities such as initiating and ending the session, structuring the conversation, building and monitoring rapport, encouraging patient participation and collaboration, and using the available time efficiently. For instance, at the beginning of the consultation, you should give a brief summary of what has happened before the consultation and what the reason for and the goal and agenda of the consultation will be. When doing this, you must be sensitive to the patient’s questions and wishes and make it clear what the patient can expect. Having this agenda will also help you to keep track of the topics that need to be covered. It means you can redirect the conversation if it starts to stray from the intended topics. In addition, during the
conversation, you can refer the patient to the agreed agenda if they dwell too long on one point or raise issues that are not really relevant.

**Case History: Ms. Peach Revisited**

“We saw each other a fortnight ago about your recurring abdominal pain. I examined you and I understood that you were worried about this pain. Last week you had some tests and I will discuss the results with you. I hope I can relieve your anxiety to some extent. After that I want to talk to you about what we can do about the pain. This will require some effort on your part, which is why I want to talk to you about it in more detail. But first I want to hear how the abdominal pain is now.”

Ms. Peach reacts with relief, feeling that she is being taken seriously, and starts to talk.

Garry briefly summarizes what she has told him, stressing the partnership between them. “I think we have discussed the main issues. Your stomach pain is not a cause for concern, but if you want less trouble with it, you will need to be more careful about what you eat and drink. I’ve given you some recommendations and I hope you’ll manage to follow them. And if you still have stomach pain, you can take antacids. We’ll see each other again in 2 months to see if the recommendations have helped. Well, as far as I’m concerned, we are finished now, unless you have any questions.”

Once all the topics on the agenda have been covered and the necessary arrangements have been made, you can end the consultation. It is helpful for the patient if you clearly mark this ending with a summary of the most important conclusions and arrangements and then give the patient an opportunity to respond to this. Obviously, you will respond to any questions the patient has. Then you should check that:

- You have given the patient any educational information you have promised.
- You have completed any documentation or forms for further appointments such as follow-up tests.
- The patient knows what to do directly after the consultation, for instance, making a new appointment at the reception desk.

Maintaining a good relationship entails:

- A friendly greeting at the beginning of the consultation and a friendly goodbye at the end
- Maintaining contact with the patient when you are doing other things such as typing in data, writing, or performing medical procedures
- Showing you are committed, painstaking, and knowledgeable
26.2.2 Explaining

**Case History: Continued**

“It doesn’t get any easier,” sighs Garry White, while having a coffee with a colleague.

“What do you mean, Garry?” asks his colleague.

“I mean explaining to a patient who’s not that bright what the options are for artificial insemination. Just talking about IVF, ICSI, and IUI, all the acronyms were driving that woman mad.”

His colleague thinks calmly about Garry’s remark for a while. Then apparently he has had a eureka moment, because suddenly he starts talking enthusiastically. “You know, Garry, do you remember that British professor at the conference we went to in Berlin last year? I can’t remember his name, but I can still remember him vividly. He gave a fantastic talk about preeclampsia. Not an easy topic, but his talk was absolutely clear. I finally understood how all those interactions work.”

“Well, yes,” sighs Garry, “it was a fantastic talk, but he was speaking to fellow doctors. I have to explain things to an ordinary woman who just really wants to get pregnant.”

Garry’s colleague is undaunted. “I don’t know, Garry. I think you can still use a lot of the techniques he used when you’re giving information to your patients. It’s about structuring and presenting your material in such a way that your patients can follow it and understand it. And if you want to do that, I don’t think it’s such a good idea to bombard them with difficult terms like IVF, ICSI, and IUI.”

The patient must be able to cognitively understand and remember the information you give. By paying attention to the structure, wording, and presentation of your explanation, you can make sure your patients can comprehend your explanation and also remember it.

In the first place, a comprehensible explanation must have a clear structure, with an introduction, body, and conclusion. The aim of the introduction is to connect the explanation to the patient’s frame of reference. You should check what the patient already knows about the topic and what questions they have. In response to this, you can then provide an overview of what you are going to explain to the patient. The body of your explanation should obviously be well structured for your own sake but also for the patient’s sake; the patient needs to be able to keep track. By dividing your explanation into core components (subtopics), you can present it to the patient in “bite-sized chunks.” In the conclusion of your explanation, you should again stress the main points and check whether your patient has fully understood your explanation and whether the patient has any more questions. Finally, you can put your patient on a firm footing by being clear about what will happen next and giving them a brochure or showing them a website so that they can read your explanation again later and also show it to other people.
You can use the following techniques to formulate your explanation in such a way that it is as understandable as possible:

- Build on what the patient already knows and wants to know.
- Make sure there is an overview.
- Be clear and specific.
- Keep it as simple as possible.
- Take it step by step, repeat main points, and invite responses.
- Enliven your explanation by giving examples and connecting it with your patient’s own experiences.
- Illustrate your explanation with a drawing from a brochure or a website.

Your presentation style can also ensure the patient understands your explanation properly and will remember it and accept it. You will need to find the right balance between calm and liveliness. Important elements are speaking style, tone of voice, eye contact, posture, and movements.

26.2.3 Listening

Case History: Ms. Taupe

“Well, Ms. Taupe, I understand very well that you want to get pregnant. And it’s not your husband. His sperm has been examined and is of outstanding quality. I think the problem must be with you. As I told you the last time I saw you, I think your excess weight is the problem. Because of that you are not ovulating and therefore there is no chance of fertilization. There are various things we can do to try to induce ovulation, but if you don’t lose weight, I don’t expect that will do much good. Apart from that, being overweight could lead to all sorts of problems if you did get pregnant. So once again, I would really advise you to lose a lot of weight before we talk again about a possible pregnancy.”

After this explanation, Dr. White leans back and waits for his patient’s response. Ms. Taupe says nothing for a long time and Mr. Taupe also stares ahead in silence. “Ms. Taupe,” says Dr. White cautiously, “what do you think of this suggestion?”

Now she looks at him and he sees tears rolling down her cheeks. “Doctor, I wish I could do that. We want a baby so badly, and I’ve really tried to lose weight, but I just can’t do it. It makes me feel really desperate.”

It is mainly Ms. Taupe’s powerless tone of voice that immediately reminds Garry of another patient: Ms. Mustard. It takes some effort—it’s not only patients who are creatures of habit—but he manages to switch to a nondirective style of giving advice. And it then soon becomes apparent that there are reasons why Ms. Taupe does what she does….
The patient must be able to assess the value of the information provided by processing it emotionally and forming a judgment. This judgment may lead to acceptance of the information and experiencing support, but it may also lead to doubts about or even rejection of the information.

A certain degree of emotional tension is required to understand the information properly and be able to process it. When this tension is absent or too strong, this will take its toll on the patient’s mental capacity. Figure 26.2 shows the relationship between the strength of emotions and the capacity to think clearly. If there is little or no emotional involvement (bottom left of the figure), little attention will be paid to the topic being discussed. As emotional involvement increases, so does the attention paid to the topic. The optimal ratio is in the middle of the curve. At this point the degree of tension and alertness is present that is required for optimal reception and processing of the information. The focus of a conversation of this kind is on the content, not on the patient’s emotions. However, sometimes the emotions are so strong—as with Ms. Taupe who badly wants to get pregnant but sees her inability to lose weight as an insurmountable obstacle to fulfilling her desperate desire for a baby—that they draw attention away from the content. The person’s attention is narrowed; information is either not heard or is strongly distorted, and there is no room for rational thinking.

Remember that while a lot of the information you give patients may have a “neutral” meaning for you, for the patient it can be highly emotionally charged, for instance, if you are discussing the need for a treatment, the postponement or an unexpected complication of a treatment, or a topic that is emotionally charged in itself. In conversations of this kind, you may be confronted with a patient’s emotions, such as feelings of fear, sadness, anger, powerlessness, loneliness, or guilt. Emotions can also run high as a result of resistance to advice you have given a patient, when a patient feels unfairly treated, when you fail to respond to certain demands made by a patient, or when a mistake has been made with an intervention. Thus, if your explanation arouses emotions in your patient, you can help calm those emotions by active listening, so that the patient will be open to further explanation. Active listening
means that you invite the patient to express their views, wishes, and feelings and show the patient you have heard and understood them. At the same time, you gain an insight into the patient’s comprehension, thoughts, feelings, and consent. Active listening also enhances rapport, because the patient feels heard, understood, and supported. Thus, active or attentive listening is regarded as an essential competence for health professionals [4, 8–11]. The main conversational skills needed for active listening are summarized later in the Tips and Tricks section of this chapter.

### 26.2.4 Influencing

**Case History: Ms. Ivory**

“Ms. Ivory, I’ve told you about the pros and cons of surgery now. We can see how it goes for a while longer and try to reduce your heavy bleeding with medication, or you can opt for this surgery. It’s entirely up to you what you prefer.”

Apparently this was not what Ms. Ivory had been hoping for, since she gives Dr. White a frightened look. “But doctor, I really don’t know,” she says timidly, “just tell me what’s best.”

Ultimately the patient, on the basis of the information provided, will have to arrive at a decision or an intention to do something or not to do it. Influencing means that the health professional helps the patient to reach a decision, such as consenting to a medical procedure or agreeing to change their behavior and to act accordingly [2, 12]. In many cases, the patient does not really have an option. On the basis of your knowledge, you advise the patient to have a certain test or undergo a treatment that proceeds according to a fixed protocol. Your “advice” then consists mainly of an explanation of the procedure and the outcome that can be expected. The patient can consent to this or not. Advice of this kind might be: “You’ve had vague stomach pains for quite some time now. I just examined you internally and didn’t find anything unusual, but I still think we should do a few more tests to be sure there’s nothing seriously wrong. Is that all right with you?”

This is known as directive advice. Sometimes you might also want to get the patient to change their behavior, as was the case with Ms. Mustard and Ms. Taupe. The patient has to do something herself, such as taking medication, doing exercises, or following certain lifestyle rules. Unfortunately, patients are not very good at following this kind of advice. For instance, 40% of medication directions are not followed or not followed correctly, and approximately 80% of recommendations about changing behavior or lifestyle (about stopping smoking, drinking alcohol, dietary recommendations, etc.) are not complied with [13, 14]. However, there are some guidelines for giving advice that significantly increase the chance that a patient will not only accept your advice but also actually follow it:
• Make sure your advice matches the patient’s request for help, wishes, and experiences.
• Give clear and practical advice.
• Give acceptable advice.
• Discuss the effects that can be expected if your advice is followed.
• Monitor compliance with your advice.

26.3 Critical Reflection

In recent years the amount of information given to patients has risen sharply. Nevertheless, many patients still feel they have not really been able or allowed to choose for themselves. To some extent this is inevitable: Directive advice simply does not offer a patient much room to make a choice. This is not a bad thing in itself if the advice is indisputably the “best” option or in the case of an emergency. However, in many cases the patient does, in fact, have a choice, and you can help them to make a well-informed decision. The shared decision-making model is now seen as the most appropriate patient-focused form of consultation between a health professional and a patient [15]. This form of consultation means that both the health professional and the patient can make their own, unique contribution to the decision-making process—the health professional as a medical expert and the patient as an experiential expert. The key points to remember about shared decision-making are:

• Stay attuned to the patient’s wishes and options.
• Offer choices. Let patients decide for themselves as much as possible.
• Help the patient to weigh up pros and cons.
• Give the patient time to reach a decision.
• Gain consent and check that you have it.

In some situations, the right choice depends not so much on medical considerations as on the patient’s views, emotions, and personal situation. In situations like this, you can help patients to become aware of their views and emotions with the help of counseling. This means breaking down the decision-making process into a number of steps, starting with clarifying the problem and then identifying and weighing up the options in order to reach a final decision. In addition to the active listening skills required to clarify and discuss the patient’s emotions, you can also use techniques to support patients, challenge them, and give them structure to help them make the decision. Sometimes a patient needs more time than one consultation affords to process the information provided, to comprehend the consequences, and to reach a carefully considered decision. You can help patients with this process by offering support after the consultation. This support may consist of:
• Making a step-by-step plan with the patient, including a contingency plan
• Providing decision aids
• Making a clear follow-up appointment
• Providing further professional support or contact with other patients with the same problems

Since the patient’s change of behavior will only take place after the consultation, you should certainly make a follow-up appointment to evaluate the change in behavior and its results. If your educational information focused on including certain behaviors in your patient’s lifestyle or even on completely changing that lifestyle, you will need several consultations to help the patient to internalize the new behavior. We refer to this as supportive guidance.

**Tips and Tricks**

Acquiring and applying communicative skills in connection with patient education are primarily a matter of learning from experience. A summary of commonly used conversational skills and techniques can be helpful. Below is a list of these skills and techniques classified on the basis of the CELI sub-competences.

**C = Control and Rapport**

• Friendly, invitational start of the consultation.
• Summarize previous history.
• Agree on the goals and topics of the consultation.
• Guide the course of the conversation, keeping to the prescribed structure.
• Monitor the patient’s attention to the conversation.
• Monitor attention and participation of other interlocutors if present.
• Provide detailed summary when changing to a new topic or ending the consultation.
• Show genuineness, empathy, care, and competence, both verbally and nonverbally.
• Announce and explain activities, such as physical examination or writing.
• Reinforce patient behavior that benefits the conversation and relationship.
• Make social conversation to show interest in the patient and put the patient at ease.
• Conclude the consultation in a clear and friendly way.

**E = Explaining**

• Ensure contents of explanation are true and realistic.
• Use clear and comprehensible language (appropriate wording, short sentences).
• Make explanation concise and structured with an introduction, items, and short summaries.
• Be interactive, leave pauses for reaction, and proceed one step at a time, guided by response—emotional or otherwise.
• Fit in with the patient’s frame of reference.
• Be convincing, use vivid examples, and tie in with patients’ experiences.
• Repeat key points and illustrate them with visual aids.
• Check patient has understood.

**L = Listen Actively**

• Be verbally and nonverbally attentive; encourage patient to talk.
• Include periods of silence; give the patient the opportunity to reflect and digest.
• Paraphrase.
• Reflect patient’s feelings and opinions.
• Ask appropriate open and closed questions to elicit facts, feelings, and opinions.
• Acquire relevant information.
• Make things specific.
• Explore inconsistencies and ambivalences.
• Summarize what the patient has said.

**I = Influencing (= Instruction, Advice, Counseling, Shared Decision-Making, and Support)**

• Offer suggestions (do not give orders); leave room for reflection.
• Useful and acceptable phrasing of instructions and advice.
• Reinforce patient’s problem-solving behavior.
• Realistic presentation of advice, possibilities, promises, and limitations.
• Take the “bad news” nature of some information and advice into account.
• Counseling and assisting with difficult decisions.
• Constructive negotiation.
• Turn a problem into a shared problem by rephrasing it.
• Promote mutual acknowledgement of feelings and opinions.
• Phase the decision process and provide time for reflection.
• Reach clear agreements and make contingency plans.
• Check the patient’s approval of suggestions, instructions, advice, decisions, and agreements.
• Offer educational material (leaflets, Internet links) and/or useful contact addresses.
• Provide personal support or professional help after the consultation.

**References**

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