Patient communication and counseling

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Summary

Patient counseling is the process of providing information, advice, and assistance to patients to improve their health, treatment adherence, and quality of life. A patient-centered approach facilitates and improves the patient-physician relationship and communication. This approach is based on open communication and shared decision-making. Health care decisions should be discussed using understandable terms and straightforward language. If there is a language barrier, medical interpretation services should be provided to the patient. For counseling and communication in specific circumstances, see the individual sections below.

General concepts of patient counseling

Key principles of communication and counseling [1][2]

- **Patient counseling**: the process of providing information, advice, and assistance to patients to improve their health, treatment adherence, and quality of life (see also "Treatment adherence" in "Managing chronic conditions").
- **Establishing the patient-physician relationship** [1]
  - Patients may feel vulnerable and have a fear of rejection/apathy from caregivers.
  - A patient's first visit is critical to the patient-physician relationship (e.g., establishing trust).
  - Empathy, interest, and continuity of care are valued by patients.

Patient-centered approach

- **Objectives**
  - Open communication between the patient and the provider, shared decision-making, and a shared goal of alleviating discomfort for the patient (see also "Decision-making capacity and legal competence" in "Principles of medical law and ethics")
  - Takes into account the patient's individual preferences, concerns, and emotions
  - Outcomes are measured and monitored (e.g. pain level, functional status)
  - Used to optimize care of chronic conditions that include multiple management strategies (e.g., pain management, cancer therapy). The patient can select those treatments which are best aligned with the patient's priorities.
- **Interviewing communication techniques**
  - Introduction and building rapport
    - Begin by introducing yourself to the patient and any accompanying person
    - Address patients by their preferred name and pronoun if provided in the intake form. Respect patient preferences communicated during the interview.
    - Seat yourself at eye level with the patient.
    - Introduce any further health care workers present at the visit.
    - Family, friends, and caregivers commonly accompany patients to health care visits. This can have benefits (e.g., emotional support for the patient, providing additional information about the patient's health, facilitating communication between the patient and physician), but may also present challenges (e.g., the accompanying person interfering with the course of the interview).

        - In patients with decision-making capacity who are accompanied by another person, verbally confirm that the patient understands that you will be discussing personal health matters and that they agree to this confidential information being shared with the accompanying person.
        - Request that any accompanying persons leave the room if the patient indicates they would prefer them to.
    - Avoid interrupting the patient during the interview and listen actively. Be polite if you have to interrupt the patient, e.g., due to time constraints.
    - Identify the purpose(s) of the visit early in the interview and structure the interview in collaboration with the patient.
        - Use **open-ended questions** to determine the purpose of the visit (see table below) .
        - Give the patient space to freely express their concerns.
        - Ask close-ended questions to collect specific information about the chief concern (e.g., "Where does it hurt", "Is it a sharp pain?").
        - Ask the patient if they have any additional concerns until you feel all concerns have been addressed (e.g., "Is there anything else you would like to discuss?").
        - Prioritize the patient's concerns based on preference and/or medical urgency.
        - Negotiate the agenda for the visit with the patient if there are many concerns to address within the scheduled timeframe. Offer to discuss remaining concerns at a follow-up visit (e.g., "Since our time is limited, let us quickly discuss which of these concerns to prioritize," "You have expressed concern about your cholesterol levels and high blood pressure; if it's okay with you, I would prefer we looked at the rash on your leg first and perhaps schedule a follow-up appointment to discuss your other concerns?").
    - Make an effort to elicit, understand, and relate to the patient's concerns and expectations (e.g., "Do you have any thoughts on what might be the cause for your high cholesterol levels?," "Does your condition cause you any particular difficulties?," "What is currently your main health concern?").
    - Show interest, compassion, and empathy for the patient's concerns to affirm the legitimacy of the patient's point of view (e.g., "I can see how this might make you feel anxious," "I'm here to help you any way I can").
    - Understanding a patient's culture and the unique needs that may come with it are a vital part of providing quality health care.
        - Consider whether a patient's culture, religion, or spirituality may affect examination and/or treatment.
        - Consider barriers to health care experienced by minority and migrant populations.
        - Be open to cultural differences and do not hesitate to involve the patient in closing your gaps of knowledge if this is relevant to the examination and/or treatment.
        - Open-ended questions provide a good means of bridging cultural gaps (see table below).
        - See also "Migrant and refugee health."
    - Summarize information provided by the patient to ensure it has been understood correctly.
    - Show that you respect and value the patient's questions and that you consider them valid throughout the interview.
    - Provide information on the (working) diagnosis and treatment options.
        - Assess the patient's knowledge and understanding of the illness.
        - Assess the patient's preference for information (e.g., "How much information would you like to receive at this time?", "Do you prefer to receive the information in stages or all at once?")
        - Provide reassurance to reduce and address fear or anxiety regarding a diagnosis or treatment.
        - Assess the patient's hopes, fears, and expectations regarding a proposed treatment to ensure that there are no misunderstandings and to help provide the appropriate emotional support.

Examples of open-ended interview questions	
Context	**Question**
• The patient's perspective on the concern	• "How would you describe the concern in your own words?"
• The patient's perception of factors leading to the concern	• "Why do you think you are experiencing these symptoms?"
• The patient's background and how it affects their concern	• "What improves or worsens your symptoms?"
• Treatment plan and follow-up	• "Do you have any concerns about the current plan of treatment?" • "Do you have any suggestions regarding your current plan of treatment?"

Examples of open-ended interview questions	
Context	**Question**
	• In patients reluctant to follow standard treatment: "Would you be open to combining alternative treatment plans with the standard medical treatment?"
• Possible barriers to care	• "Is there anything that would prevent you from seeking care in a standard medical institution?"

PEARLS model

- **Definition**: a psychosocial model that aims to help caregivers express empathy and support emotions in order to build a trusting relationship with patients
- **Components**
  - Partnership: Reassure the patient of your commitment to the collaborative goals, offer resources.
  - Empathy: Acknowledge and validate the patient's emotions.
  - Apology: Take responsibility if appropriate (e.g., for a long waiting time).
  - Respect: Commend constructive patient behavior (e.g., attending a doctor's appointment, remaining optimistic).
  - Legitimization: Validate and acknowledge the patient's emotions (e.g., frustration, anger).
  - Support: Offer and ensure support.

Language

- **General considerations**
  - Avoid judgemental or defensive language or behavior.
  - Discuss health care decisions with patients in relatable terms (e.g., avoid medical jargon, tailor language to the patient).
- **Language barriers**
  - Ask the patient questions to assess language proficiency before starting an interview.
  - If there is a language barrier between the patient and caregiver, establish the patient's preferred language and use a **professionally trained medical interpreter**.
  - Spoken interpretation services are available in person, via video call, or telephone.
  - Deaf patients or patients with hearing impairment should be offered a medical interpreter trained in American Sign Language. Other communication options include computer-assisted real-time transcription and assistive listening devices.
  - Having a family member interpret should be avoided unless it is the patient's wish (in which case, this should be recorded in the patient's chart).
  - A professionally trained medical interpreter should be present even if the appointment is limited to a physical examination.
  - Interpretation by nonqualified individuals (e.g., family members, medical staff) may be necessary in certain (e.g., emergency) situations in which delaying care in order to access interpreter services might result in patient harm.
- **Interviewing techniques when an interpreter is present**
  - Introduce the interpreter to the patient.
  - Position of the interpreter
    - Spoken language: slightly behind or next to the patient
    - Sign language: behind the physician
  - Address the patient, not the interpreter, and maintain eye contact.
  - Avoid third-person statements, keep phrases short, and ask one question at a time.

- Allow extra time for the interview.

Psychosocial counseling

- **Definition**: care related to the emotional and psychological well-being of the patient and their family members.
- **Principles**
  - Aims to reduce both psychological distress and physical symptoms by increasing quality of life and enhancing coping (e.g., identify and treat anxiety and depression)
  - Based on good communication, assessment, and interactional skills (e.g., compassion, empathy) to build a rapport with the patient and their family.
  - Encourages patients to express their feelings about the disease (e.g., consequences, relationships, self-esteem issues)
  - Provides psychological and emotional well-being tools for patients and their caregivers

Enabling behavioral change

- Patients should be encouraged to participate in treatment and therapy decisions.
- Shared decision-making enables patients to make informed choices.
- Motivational interviewing can be a helpful tool to strengthen a patient's motivation to change behavior (e.g., substance use disorders, lifestyle changes).
  - Aims to explore and resolve ambivalence about changing behaviors by eliciting the patient's reasons for change
  - Helps to assess the barriers that make behavioral change difficult for the patient

Transtheoretical model of behavioral change

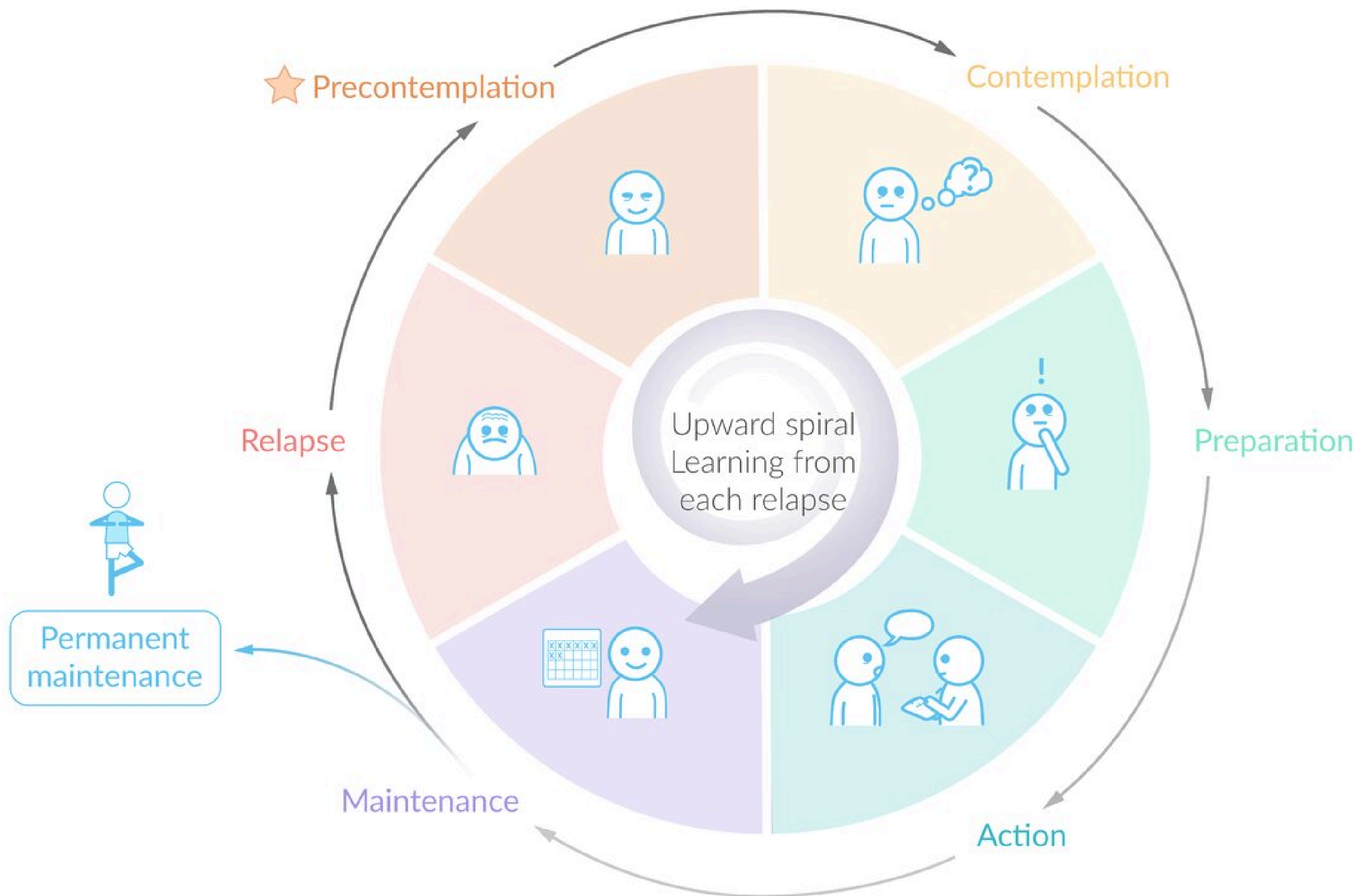
- **Definition**: a biopsychosocial model that focuses on an individual's intentional change of behavior
- **Objectives**
  - To assess an individual's readiness to modify a certain behavior
  - To provide strategies to guide the individual, e.g., in overcoming substance use disorder, managing weight, adhering to medication

Stages of behavioral change

	Patient behavior	Interviewing techniques
Precontemplation stage	• Denies or is unaware of the problem and its consequences	• Encourage introspection by asking open, probing, and nonjudgmental questions that explore the patient's perception of the situation. • Emphasize your availability and the importance of follow-up visits. • Demonstrate the discrepancy between the patient's personal goals and values and current behavior.

Contemplation stage	• Aware of the problem but unwilling to change it	• Discuss the benefits and disadvantages of the patient's current behavior.
		• Use a readiness-to-change scale to determine the patient's motivation to change (e.g., “On a scale of 1 to 5, how ready are you to lose weight?”) [3]
		• After the patient states a number, ask the patient why they picked this number rather than a lower one.
		  ◦ This approach applies the framing effect to an individual's decision matrix.
		  ◦ It encourages the patient to reflect and focus on the disadvantages of the current state and the benefits of change (instead of the benefits of the current state and disadvantages of change), thereby enabling further discussion on the reasons to embrace change.

Stages of behavioral change		
	Patient behavior	**Interviewing techniques**
		• Suggest possible ways to support behavior changes.
Preparation stage	• Preparing to make a change	• Help to set achievable goals and provide resources. • Encourage changes and adjust expectations as necessary. • Use motivational interviewing.
Action stage	• Demonstrates a change in behavior	• Help to maintain change by collaboratively developing coping strategies (e.g., identifying/avoiding triggers) and self-help strategies. • Emphasize positive changes that have been made. • Acknowledge difficulties.
Maintenance stage	• Maintains behavioral changes and integrates them into lifestyle	• Support and praise ongoing positive changes. • Assess the risk for relapse. • Provide support, encouragement, and reinforcement.
Relapse stage	• Behavioral changes are reversed.	• Reassure the patient of ongoing support, availability, and the possibility of change. • Encourage a return to prior behavioral changes. • Help the patient to learn from the relapse.



5 As model of behavior change

- **Definition**: an evidence-based behavioral intervention strategy originally developed for smoking cessation that can be adapted for multiple behaviors and health conditions to help individuals with intentional behavior change [4][5]
- **Components**
  - Assess the patient's behavior, beliefs, knowledge, and level of motivation.
  - Advise the patient on personal health risks and the benefits of change.
  - Agree on appropriate treatment goals and methods (shared decision-making).
  - Assist the patient to identify personal barriers, create self-help strategies, access social or environmental support for behavioral change, and supplement with adjunctive medical treatments if appropriate.
  - Arrange specific plans for follow-up support to provide ongoing support and adjust the treatment if necessary.

Directive counseling (prescriptive counseling) [6][7][8]

- **Definition**: an approach to counseling in which the physician assumes an active role in guiding the therapeutic process along lines that they consider relevant and in the best health interests of the patient
- **Principles**
  - While providing directive counseling, the physician should:
    - Provide information objectively and ensure that there is no element of duress, coercion, or manipulation in guiding the therapy.
    - Keep in mind that patient autonomy always takes precedence and that patients with decision-making capacity can refuse to follow the physician's recommendations.
  - Examples of situations in which directive counseling is applicable include:
    - The patient is making a decision (e.g., due to knowledge deficit or wrong beliefs) that is detrimental to their own well-being (e.g., opting for a home birth when it is contraindicated, opting for home remedies to treat early-stage cancer, continuing to drive despite being unfit to do so)
    - The patient requests a test or treatment that is inappropriate or ineffective.

Counseling on substance use disorders

See also "Substance-related and addictive disorders" for more information.

- **SBIRT approach**: screening, brief intervention, referral to treatment [9]
  - Aims to enable early intervention for patients with, or at risk of developing, substance use disorders
  - Used in primary care centers, emergency rooms, or trauma centers
  - Brief intervention is used to increase insight and awareness regarding substance use and to motivate behavioral change.
  - Referral to specialty care ensures more extensive treatment.
- **Techniques for counseling on substance use disorder**
  - Motivational interviewing
  - Transtheoretical model of behavioral change
  - 5 As model of behavior change
- **General principles of addiction counseling**
  - Can be individual or group counseling (e.g., Alcoholics Anonymous)
  - Includes patient education
  - Aims to help patients avoid people or situations that might trigger substance use
  - May also incorporate cognitive, behavioral, and/or supportive psychotherapies (see "Psychotherapy and defense mechanisms")

Counseling on smoking cessation

Using the 5 As model of behavior change, the clinician should:

- Ask: Inquire about and document the use of tobacco.
- Advise: Urge quitting with clear and personalized language.
- Assess: Assess the patient's willingness to quit.
- Assist: Provide resources to help the patient quit.
- Arrange: Schedule regular follow-ups.

Smoking is the single greatest preventable cause of death in the US, regardless of age at the time of quitting or the number of previous pack years. [10]

Counseling on alcohol use disorder

- Provide feedback to the patient regarding their level of alcohol consumption and engage the patient in a conversation using reflective or motivational interviewing
- Inform the patient about psychosocial support groups (e.g., Alcoholics Anonymous).
- Inform the patient about pharmacological treatment options (e.g., naltrexone, disulfiram).
- Assess the patient's readiness to change by using the transtheoretical model, and schedule regular follow-ups.

Counseling on illicit drugs

- Engage the patient in a conversation using reflective or motivational interviewing
- Provide feedback to the patient regarding their level of drug consumption.
- Assess the patient's readiness to change by using the transtheoretical model and schedule regular follow-ups.

Counseling on the use of prescription opioids

- Inform patients about the possibility of opioid intoxication, addiction, adverse effects, and opioid withdrawal (see “Opioid intoxication and withdrawal”).
- Educate patients on buying opioids only from licensed pharmacists and stores.
- Stress that patients should take opioids exactly as prescribed and that they should not use opioids prescribed for someone else.
- Patients should avoid mixing opioids with any other drugs, especially alcohol or sedatives (e.g., benzodiazepines).
- Establish specific SMART goals for opioid therapy.
- Opioids should be stored in their original containers, out of sight/reach of children.
- Physicians should address suspected opioid misuse in a nonjudgmental, collaborative discussion with the patient that aims to understand the reasons for misuse.

Counseling on lifestyle modifications

- Lifestyle modifications involve altering long-term habits, and adopting and maintaining healthier behaviors.
- Lifestyle modifications can be used to treat a wide range of conditions (e.g., cardiovascular diseases, obesity).
- Cardiovascular diseases are the leading cause of death in the US for both men and women.
  - In one hour, approx. 83 people in the US die from heart disease and stroke.
  - More than 25% of these deaths could have been prevented or delayed by lifestyle modifications that help control modifiable risk factors and promote healthier behaviors (e.g., smoking cessation, regular exercise).
  - See “Etiology” and “Primary and secondary prevention of atherosclerosis” in “Atherosclerosis” for more information.
- Many people in the US are affected by sleep disorders (e.g., insomnia) or insufficient sleep. [11]
  - Insufficient sleep has been linked to the development of chronic diseases (e.g., type 2 diabetes, cardiovascular disease, obesity, depression).
  - Sleep hygiene interventions target behavioral habits that negatively impact sleep.
  - See “Sleep and sleep disorders” for more information.
- The prevalence of obesity in the US is approx. 42% and has been increasing substantially in the past decades, and behavior modification is a cornerstone of therapy. [12]

Reference:[10]

Counseling on support options for regular exercise and diet changes

- **Counseling on regular exercise**
  - Patients should have 150 minutes of moderate aerobic activity or 75 minutes of vigorous aerobic activity per week. [13]
  - The specific activity or sport should be tailored to patient preferences to increase the likelihood of adherence.
- **Counseling on weight and diet changes**
  - Suggest including family members or friends in diet and exercise plans to enhance social support.
  - Encourage patients to increase physical activity.
  - Encourage regular weighing.
  - Encourage patients to monitor what they eat and develop stimulus control (e.g., buying fewer calorie-rich foods).
  - Provide education on nutrition.
  - Set realistic goals in collaboration with the patient.

Selfmonitoring of daily weight, food intake, and exercise is associated with increased success rates and greater long-term maintenance of weight loss.

Counseling on sleep hygiene and lifestyle modifications to improve mood

- **Counseling on sleep hygiene**
  - Recommended amount of sleep per night [14][15]
    - Older adults (> 65 years): 7–8 hours
    - Adults (19–65 years): 7–9 hours
    - Teenagers (13–18 years): 8–10 hours
    - School-aged children (6–12 years): 9–12 hours
    - Preschool children (3–5 years): 10–13 hours
    - Toddlers (1–2 years): 11–14 hours
    - Infants (< 1 year): 12–15 hours
    - Newborns (< 4 weeks): 14–17 hours
  - Encourage patients to maintain a regular sleep schedule.
  - Advise patients to avoid the following:
    - Stimulants (e.g., caffeine, nicotine) in the evening
    - Exposure to electronic screens before bedtime
    - Naps
  - Encourage regular exercise.
- **Counseling on lifestyle modifications to improve mood**
  - Educate patients on relaxation techniques.
  - Encourage regular exercise.
  - Educate patients on mindfulness and meditation.

Counseling on sexual health and contraception

- **Taking a sexual history**
  - Routinely incorporate sexual history into primary care.
  - Adolescents > 12 years of age should be interviewed alone and confidentiality should be ensured.
  - To take a baseline sexual history, the 5 Ps can be used to determine a patient's sexual health needs. [16]
    - Partners: Ask the patient about the number and gender(s) of sexual partners.

        - Pregnancy: Ask the patient whether they want to avoid pregnancy or are planning a pregnancy.
        - Practices: Ask which types of sex are practiced (e.g., oral, vaginal, anal).
        - Protection against STIs: Ask about the protective measures against STIs currently used by the patient or their partner(s).
        - Past history of STIs: Ask the patient if they have a previous history of STIs.
    - See also "Communicating with transgender and gender-diverse patients" below.
- **Counseling on safe sex practices**
    - Inform patients about factors that increase the risk of contracting STIs (e.g., not using condoms, multiple sex partners).
    - Discuss testing (e.g., HIV testing) and the benefits, risks, and limitations of different contraceptive methods.
- **Counseling on contraceptive options**
    - Discuss the patient's priorities regarding whether, when, and how to have children.
    - If the patient wishes to know about contraceptive options, discuss their effectiveness and adverse effects.
    - Hormonal contraceptive options (reversible)
        - Most effective: contraceptive implants and intrauterine devices with progestin
        - Other options include injectable contraceptives, oral contraceptives, and transdermal patches.
    - Nonhormonal contraceptive options
        - Most effective: vasectomy (may be irreversible), female sterilization (irreversible), and intrauterine devices (reversible)
        - Less effective, reversible options include diaphragms and condoms.
    - For more information on contraceptive methods, see "Hormonal contraceptives" and "Nonhormonal contraceptives."

Counseling on support options for domestic violence

- **Screening for intimate partner violence (IPV)**
    - At initial visits or routinely
    - If a patient mentions a new intimate relationship
    - At prenatal and immediate postpartum visits
    - If a patient presents with concerning trauma or symptoms consistent with IPV
    - Screening should be conducted using standardized questioning tools (e.g., abuse assessment screen).
- **Counseling on IPV**
    - Encourage disclosure by asking direct, open-ended questions and ensuring confidentiality.
    - Summarize the patient's answers back to them to make sure you have understood them correctly.
    - Express empathy, validation, acknowledgment, and nonjudgmental support following disclosure of IPV.
    - Thoroughly document the details of abuse.
    - Assess the patient's willingness to take action and evaluate whether the patient is currently safe.
    - The patient should be referred to a social worker or domestic violence advocate/hotline for advice on preparing a safety plan.
    - Do not encourage patients to leave the relationship.
    - Counsel and evaluate for psychological comorbidities.
    - For more information on IPV, see "Domestic violence" and "Ethically challenging situations" in "Principles of medical law and ethics."

Clinicians should not encourage patients to leave an abusive relationship but should support them if they come to that decision on their own.

Counseling for patients with memory loss and/or cognitive impairment

- **General considerations**

    - Evaluate emotional stability (e.g., suicidality), safety risks, adequacy of supervision, and whether there is evidence of neglect.
    - Clinicians should have contact information for the patient's caregiver or next of kin, who should be advised to determine whether the patient is adequately handling finances, medications, and other responsibilities.
- **Interviewing techniques**
    - Use concrete, direct, and specific language.
    - Provide a quiet, nondistracting space for the interview.
    - Adjust questions to the patient's level of comprehension.
    - Do not make assumptions about a patient's abilities (e.g., literacy).
    - See "Communicating with patients with disabilities" below.

Counseling for patients with chronic diseases and/or terminal illness

Patients with chronic/terminal diseases can feel isolated, frustrated, and/or hopeless. These patients should be counseled on learning how to handle difficult emotions and develop an understanding of their disease. See "Grief and end-of-life counseling" for more information on counseling patients with terminal illness.

- **Counseling for chronically ill patients**
    - Emphasize that the patient is not alone and offer referral to support groups.
    - Listen to the patient's frustrations and challenges and empathize with them; do not dismiss their concerns.
    - Avoid platitudes such as "Everything will be OK" or "I'm sure you'll feel better soon."
    - Discuss why treatment adherence is important for slowing or reversing disease progression.
    - Counsel the patient on lifestyle modifications to improve mood.
    - Educate patients on mindfulness and meditation.
    - Spiritual counseling: See "End-of-life counseling for patients."
    - See also "Managing chronic conditions" for more information.
    - See also "Psychosocial models" in "Overview of palliative medicine" and "Psychosocial counseling."

Counseling for patients following disfiguring injuries or surgeries

- Following disfiguring injuries or surgeries (e.g., amputations, facial injuries), patients frequently experience psychiatric distress and are at an increased risk for psychiatric disorders (e.g., major depressive disorder, posttraumatic stress disorder, social phobia).
- If a patient feels unattractive:
    - Explore the patient's reaction to their condition with an open question.
    - Do not give false reassurance.
    - Use a patient-centered approach to listen actively to the unique concerns expressed by the patient.
    - Discuss further treatment options if necessary.

Reference:[17][18]

Counseling on sudden infant death syndrome (SIDS)

To prevent SIDS, physicians should educate parents on the following measures:

- Babies should be placed to sleep on their backs and on a firm surface.
- Encourage mothers to breastfeed for as long as possible.
- Avoid exposing the baby to cigarette smoke.

- There should be no pillows, loose bedding, or blankets in the crib where the baby sleeps.
- Avoid overheating the baby.
- The baby should sleep in the same room as the parents but not in the same bed.
- The use of a pacifier can also reduce the risk of SIDS.

Counseling on pregnancy loss

- **General considerations** [19][20]
  - Normal grief, which may involve depressed mood, loss of appetite, and insomnia, is a normal reaction to pregnancy loss.
  - Pathological grief reactions include bereavement-related major depressive disorder and prolonged grief disorder
  - Patients who undergo **termination of pregnancy** for medical reasons also commonly experience grief reactions.
  - For more information, see "Bereavement and grief."
- **Approach** [19][20]
  - Patient-centered care: focus on the uniqueness of each family rather than a standardized approach.
  - Be sensitive to the diversity and individuality of grief.
  - Show respect for the deceased child.
  - Be sensitive to sociocultural diversity and supportive of the patient processing their loss according to their beliefs and customs.
  - Create an empathetic and caring environment, especially with regard to verbal and nonverbal expression (e.g., active listening, using supportive silence and eye contact when appropriate, compassionate communication).
  - Educate individuals about psychotherapy options and support groups.
  - Offer reproductive life-plan counseling.
  - Educate individuals affected by pregnancy loss about potential causes and the options for future family planning available to them.
    - Empower affected individuals to make informed decisions (e.g., concerning the mode of birth, whether or not to have an autopsy or further genetic analyses).
    - For further information on questions of pathophysiology and etiology, see "Pregnancy loss."
  - Support the patient in creating memories. [20]
    - Encourage the patient to see and/or hold the baby.
    - Support and encourage the patient in saving mementos (e.g., naming the baby, creating an impression of the baby's footprint, taking a photo of the baby, collecting items such as ultrasound images, wrist bands, etc., from hospital admission).

Communicating with transgender and gender-diverse patients

See "Affirmative care" in "Sexuality and sexual medicine".

Communicating with patients with disabilities

- **General considerations**
  - Use a normal tone of voice and talk directly to the patient.
  - Caregivers accompanying the patient may provide additional information if necessary.
  - Ask the patient if they need assistance, do not assume help is needed.
  - When communicating with family members or caregivers, apply people-first language, e.g., "a person with a disability" instead of "the disabled (person)."
  - Make eye contact.
  - If a physical examination is necessary, do not miss out any relevant components.

- Only address the patient's disability if it is relevant to the visit.

- **Communicating with patients who have hearing loss**
  - Ask the patient about their preferred means of communication (e.g., sign language, lip reading).
  - Allow extra time for the interview.
  - Make use of visual/tactile signals to maintain the patient's attention.
  - Offer a medical interpreter trained in American Sign Language. Other communication options include computer-assisted real-time transcription and assistive listening devices.
  - Ensure that your lips are visible to the patient; if droplet precaution measures are necessary, a transparent surgical mask should be worn. [22]
  - See “Interviewing techniques when an interpreter is present” in “General concepts of patient counseling” above.
- **Communicating with patients who have speech difficulties**
  - If you have difficulties understanding a patient, ask them to write down the information.
  - Repeat information provided by the patient to ensure correct interpretation and/or understanding.
  - Eliminate background noise and distractions.

Trauma-informed communication

- **Behavioral health screenings for patients with a history of trauma**
  - Substance use
  - Social support
  - Suicide risk
  - Trauma-related symptoms interfering with social/occupational function
- **Interviewing techniques** [23]
  - Avoid asking the patient to repeat their trauma history (review the patient's chart instead)
  - Emphasize confidentiality.
  - Inform the patient about what to expect during the history taking and, if relevant, during a physical examination.
  - If the patient requires a physical examination, inform them beforehand that they determine the pace and/or continuation of the examination and can signal at any time if there is emotional or physical discomfort.
  - Ask the patient for permission before conducting each part of the physical examination.
  - Let the patient know that they can have one or more friend or family member present in the room for support.
- The 4 R's of trauma-informed care
  - **R**ealize the widespread impact of trauma and understand the potential paths to recovery.
  - **R**ecognize the signs and symptoms of trauma in patients, families, staff, and others involved with the system.
  - **R**espond by fully integrating knowledge about trauma into policies, procedures, and practices.
  - Avoid **R**etraumatization.

Culture in the health care setting

Culture as an aspect of health and medicine

- Culture is the set of ideas, social behaviors, and customs shared by a group of people as a defining factor of their social cohesion. Manifestations such as religion, ethnicity, language, and nationality can be regarded as elements of culture as well as cultures in their own right.
- Culture shapes people's perceptions of and views on health, disease, and medicine.

- Accordingly, culture also shapes the way people experience and manifest symptoms as well as how they express the experience of symptoms.

Cultural concepts of distress

- The interaction between health and medicine in a specific cultural context can give rise to cultural concepts of distress, which refers to cultural idioms, explanations, or conditions that individuals from the corresponding culture use to describe and contextualize symptoms (see below for details).
- Such descriptions may have no correspondence to concepts of evidence-based medicine, making diagnosis and treatment difficult.
- To avoid misdiagnosis and provide the best possible care, physicians should be aware of the patient's cultural background. This is best done with the help of a cultural formulation interview.

Types of cultural concepts of distress

- **Cultural explanations/perceived causes of distress**: culture-specific etiological models for symptoms, illness, or distress. Such models may be founded on traditional medicine as well as cultural manifestations such as folklore, religion, and diet.
- **Cultural idioms of distress**: culture-specific expressions for symptoms or states of distress
- **Cultural syndromes**: clusters of psychiatric and/or somatic symptoms that occur exclusively in a specific culture or context and are generally recognized as medical conditions in the respective communities

Examples of cultural syndromes

- **Ataque de nervios ("attack of nerves")**
  - An acute syndrome among individuals of Iberian origin or descended cultures (e.g., Hispanic, Caribbean) characterized by intense emotional distress (typically anxiety, anger, or grief) and a sense of losing control
  - Symptoms include uncontrollable screaming and crying, trembling, verbally and/or physically aggressive behavior, palpitations, chest tightness, breathlessness, a sensation of heat rising up to the head, sweating, fainting, dissociative experiences (e.g., amnesia, depersonalization), and seizure-like episodes.
  - Typically precipitated by stressful events in the family (e.g., death, divorce, accidents, conflict) or, less commonly, the accumulated experience of suffering
  - Manifestations may resemble panic attacks, specific or unspecific dissociative disorders, and conversion disorder.
- **Khyal cap ("wind attack")**
  - An acute syndrome among Cambodian individuals and those of Cambodian descent characterized by symptoms of panic attacks (e.g., palpitations, tachycardia, anxiety) and autonomic arousal (e.g., neck soreness, tinnitus)
  - Attributed to disruptions of the flow of khyal (a form of inner "wind" comparable to air and pneuma in classical humoral theory) in the body.
  - Often meets the criteria of panic attacks and may be associated with PTSD [24]
- **Taijin kyofusho ("disorder of fear of interpersonal relations")**
  - A syndrome among Japanese individuals and those of Japanese descent characterized by social anxiety about and the avoidance of interpersonal relations due to a sense of inadequacy or feeling that one's actions or appearance may be offensive to others
  - Social situations or their anticipation may trigger panic attacks.
  - Manifestations may meet the criteria of social anxiety disorder, body dysmorphic disorder, and delusional disorder.
- **Dhat syndrome ("semen loss")**
  - A broad range of symptoms seen in South Asian male individuals and those of South Asian descent characterized by fear attributed to the loss of "dhatu," one of the seven essential bodily humors in Ayurvedic medicine (generally equated with semen).
  - Common manifestations include fatigue, anxiety, erectile dysfunction, weight loss, and depressive mood in absence of any physiological dysfunction.

Cultural considerations in clinical care

- A patient's cultural background may influence their views on health and health care and affect their preferences and decisions regarding treatment.

    - Such preferences and decisions may conflict with standard clinical practice and/or physician values. [25][26]
    - Physicians should make an effort to understand and accommodate cultural differences with their patients' best health interests in mind.
    - Physicians should not provide treatments that they believe are unethical or harmful, regardless of any cultural concerns.
    - Physicians should respect the cultural values and precepts of their patients and tailor the clinical approach accordingly. [27]
- A direct conversation with the patient about their cultural background can help to improve mutual understanding. [25][27]
    - An interpreter should be involved if there is a language barrier between a physician and a patient (see "General concepts of patient counseling" in "Patient communication and counseling" for more information about the use of interpreters).
    - If needed, social workers, chaplains, or team members with the same cultural background may be involved in the conversation.
    - Physicians may not override a capable patient's wish to refuse treatment, even if the wish is motivated by cultural precepts that conflict with standard clinical practice. However, physicians may offer education to convince patients to reconsider refusing treatment, recommend against treatments they believe are ineffective, and refuse treatments that they believe are harmful or unethical.
- **Cultural formulation interview**
    - A set of questions asked during a mental health examination in order to assess a patient's perception and experience of psychiatric symptoms within their cultural context, including cultural factors that influence the way the patient perceives the manifestation and cause of the distress as well as the actions they take to resolve distress
    - Promotes physician-patient communication, helps avoid linguistic and/or cultural misunderstandings, enhances the patient's cooperation during the mental health examination, increases the accuracy of diagnosis and therapeutic planning, and helps bridge any cultural differences between the physician and the patient that may hinder treatment

Genetic counseling

- **General considerations**
    - In the US, genetic counseling is provided by specially trained professionals called "genetic counselors." [28]
    - All the principles of medical ethics apply also in genetic counseling.
- **Purposes**
    - Providing families information about the nature of a genetic disease and/or predisposition to a multifactorial disease with a strong genetic influence (e.g., type 2 diabetes mellitus, certain types of cancer)
    - Discussing possible risks and benefits of genetic testing
    - Performing and interpreting genetic tests
    - Supporting individuals to make informed choices about their reproductive options (for more information, see "Preconception counseling")
    - Counseling on treatment of genetic diseases
    - Helping individuals and their families cope with the psychological burden of a genetic disorder
- **Responsibilities of genetic counselors** [29]
    - Discussing the risks and benefits of genetic testing with patients
    - Screening for genetic conditions in certain populations (e.g., for Tay-Sachs disease in Ashkenazi Jewish individuals)
    - Genetic risk assessment (e.g., for certain types of cancer)
    - Diagnostic testing in individuals suspected of having a genetic disorder
    - Preimplantation testing (possibly in the setting of assisted reproduction)
    - Interpretation of test results
    - Educating individuals and families with a genetic disease and/or a predisposition to a multifactorial disease with a strong genetic influence (e.g., type 2 diabetes mellitus, certain types of cancer) about the nature of the disease
    - Counseling on the management of a genetic disease
    - Helping individuals and families cope with the psychological burden of a genetic disorder
- **Types**
    - Pre-test counseling: focuses on evaluating the need for a test and informing the patient about the purpose of testing, details of the test (e.g., its strengths and limitations), possible consequences of testing, and obtaining informed consent

- Post-test counseling: focuses on delivering the test results, providing education about the disease, discussing management options, providing psychological support

- **Elements of a genetic counseling session**
  - Taking a history of the disorder and family history
  - Pedigree analysis (if applicable)
  - Discussing the appropriate genetic test (see “Genetic testing” for indications for individual genetic tests)
  - Obtaining informed consent for genetic testing: A patient should be informed about the benefits and risks of genetic testing, possible findings genetic testing can reveal, and the ways the obtained information may influence disease or risk management.
  - Result disclosure and discussion
  - Psychological support

References:[30][31]

Counseling on complementary and alternative medicine

- Explore the patient's reasons for requesting complementary and alternative treatment.
- Discuss the risks and benefits of these treatments.
- Be open to integrating modalities with proven safety and efficacy.
- Consider referral to an appropriate complementary or alternative medicine provider.

Counseling on clinical uncertainty

- **Patient is uncertain about a certain treatment/diagnostic step**
  - Acknowledge the degree of uncertainty.
  - Convey the potential seriousness of the situation.
  - Include an individualized discussion of differential diagnosis based on known facts of the case.
  - Explain the need for further evaluation.
  - Include a clear plan for follow-up.
  - Allow the patient an opportunity to ask questions.
- **Patient declines a recommended treatment/diagnostic step**
  - Provide accurate and complete information on the procedure.
  - Provide a balanced assessment of the recommended intervention, including benefits, risks, and limitations.
  - A thorough explanation of further medical steps and plans can reinforce patient autonomy and improve decision-making.

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