Family Medicine and Community Health

Storylines of family medicine VI: ways of being—in the office with patients

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ABSTRACT

Storylines of Family Medicine is a 12-part series of thematically linked mini-essays with accompanying illustrations that explore the many dimensions of family medicine, as interpreted by individual family physicians and medical educators in the USA and elsewhere around the world. In 'VI: ways of being—in the office with patients', authors address the following themes: 'Patient-centred care—cultivating deep listening skills', 'Doctor as witness', 'Words matter', 'Understanding others—metaphor and its use in medicine', 'Communicating with patients—making good use of time', 'The patient-centred medical home—aspirations for the future', 'Routine, ceremony or drama?' and 'The life course'. May readers better appreciate the nuances of patient care through these essays.

INTRODUCTION

The conduct of family physicians during their encounters with patients matters. Do family physicians fully practise patient-centred care? Do they truly listen to the words their patients voice? Are they willing to consider the deeper meanings behind their patients' expressed concerns? Do they use words that work to engage patients and encourage agency? Are their clinics organised and run in such a way that welcomes communication and trust? Attending to these questions helps family physicians—indeed, all physicians—better address the needs of their patients and respond in ways that promote health and healing.

PATIENT-CENTRED CARE—CULTIVATING DEEP LISTENING SKILLS

Lisa LaVallee

Patient-centred care is about three things: listening, listening and listening. Listening means both paying attention and training oneself to be a skilful receiver of patients' concerns.

Paying attention takes time, but often less than one might think. Training to be a skilful listener is a career-long pursuit, which involves practising curiosity, understanding the context of care and attending to one's own biases. For family physicians, listening is important because patients' histories are key to ensuring accurate diagnoses and because community determinants of health influence the risk of disease, treatment options and overall prognosis.

Akin to a bloodhound's ability to follow a scent without being consciously aware of it, paying attention combines many skills in one innate human ability:

- **Set intentions**—Be present and open with patients. Take three breaths before entering an examination room as a reminder to let go of distractions.
- **Plan an agenda**—Consider which problems need follow-up or which preventive measures need attention.
- **Be ready**—Prepare to abandon some or all of the preplanned agenda to address patients' particular concerns. Certainly, patients' agendas take priority when their safety is of concern (eg, when patients present with severe depression, signs of domestic violence or exertional chest pressure).
- **Lead with open-ended questions**—'How can I help you?' is a reasonable starting point.
- **Set an agenda together**—'Can we make a list of the things you want to talk about?' Remember that putting some things off until future visits can give practitioners the space they need to demonstrate their best listening skills.
- **Invite explanations**—'Please tell me more about your concerns.' Let patients tell their stories. Rarely will patients talk for more than three minutes.

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Figure 1 Practise *deep listening*.

- **Find balance**—Clinic visits generally combine two agendas: the agenda of the practitioner and of the patient.
- **Practise 'face time'**—Look directly at patients, not at the computer. This communicates respect, openness and an intent to help. It also helps clinicians show that they are interested in patients' stories.
- **Recognise differences**—Understand that differences in privilege, power, culture, language, trust and expectations exist between clinicians and patients.
- **Demonstrate curiosity**—Show interest in the lives of patients beyond their clinical presentations.
- **Align with patients' narratives**—Invite a shared presence with patients, validate their feelings and note both their worries and the things that give them strength.
- **Pause and probe**—Confirm what patients have said and follow leads to discover what was not said.
- **Pay attention**—Recognise and process reactions on both sides of the stethoscope.
- **Allow for silence**—Create a welcoming space for concerns, fears and hopes to emerge.
- **Learn to understand**—Appreciate how anger often suggests fear, apathy, loneliness, depression, dissatisfaction or uncertainty.
- **Give up control**—That is when real healing can occur.

These skills of receiving and processing information help family physicians demonstrate interest; they also help them grow in self-awareness and relational-awareness. And remember, listening—*deep listening*[1]—is therapeutic in and of itself (figure 1).

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DOCTOR AS WITNESS

David Loxterkamp

Doing 'nothing' other than offering companionship, support and affirmation to our patients is among the most important things that family doctors do.

Family doctors routinely bear witness to suffering; moreover, we are invited to join our patients as they travel down the difficult road of illness. Even when we feel an aversion to them—the sight of their disfigurement, the smell of haemorrhage, the feel of scarred flesh, the sound of panic—we stand by them (figure 2).[2]

As clinicians, we often focus on 'results', largely in the form of disease markers like haemoglobin A1c, blood pressure or low-density lipoprotein. This obsession can discount the value of the companionship, validation and reassurance we also offer. Yet, even when 'all we do' for our patients is listen to them and try to understand them, they still return. Perhaps our attempt to bear witness to their experience is exactly why they do.

For many patients, the family doctor is the person who cares most for them. We don't strike or manipulate them. We listen to their worries, touch their wounds, withhold judgement and vow not to abandon them. We hear, often for the first time, secrets of infidelity, trouble at work, abuse at home or a desire to hurt themselves. Patients do not come to their family doctors for advice so much as for an acknowledgement and acceptance of who they are.

A patient was admitted to our family medicine teaching service. This was her fifth hospitalisation for alcohol detoxification in the last three years. She was in her mid-40s, married, unemployed and showing signs of liver damage. She confided that her husband was about to leave her. No one, least of all the patient, was hopeful about her future.

I asked if I could speak with her and her husband. She smiled but looked away. I asked when he would be visiting.

'Today at two o'clock,' she replied.

'Would you mind if joined you?' I asked.

Figure 2 Doing by being. Copyright L Johnson. Used with permission.[2]

Figure 3 Use words wisely.

At the family meeting later that day, I began to understand certain things. The patient's binge drinking predictably followed a telephone call from her parents. She could not find work as a certified nursing assistant because of an old drug-related felony conviction. Her husband was threatening to leave because he could no longer bear being just a caretaker. Then came the biggest surprise of all: no one, during any of her previous hospitalisations, had helped the patient plan for sobriety. I simply listened. Later, she and I made a list of intentions and discussed it daily, and I followed up with a letter of encouragement one week after her discharge.

Witnesses cannot be silent about what they see, especially in the face of injustice or violence. We must act with moral integrity, adhere to codes of ethics and uphold the law. To sit with those who suffer and bury that experience inside can only harden or destroy a person. Family doctors must consciously and consistently support each other. This, too, is part of the work of family medicine—acting in response to the needs of patients, colleagues and society at large.[2]

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WORDS MATTER

Jonisha Brown and Dael Waxman

Words form the language people use to communicate with others around them. Use words wisely to enhance relationships with patients and improve their overall experience.

To communicate effectively and build therapeutic relationships, family physicians must understand the power of the words they use and must pay attention to how those words are received by their patients. Setting the stage for positive patient outcomes means attending to two key concerns.

First, cultural backgrounds are foundational to the thoughts and beliefs that determine the words people use, even in healthcare.[3] Simply because of their training in medicine, the vocabulary of physicians is often quite different from the vocabulary of their patients. Furthermore, family physicians may find themselves in clinical encounters where culturally—beyond the narrow realm of medicine—they have little in common with their patients. To avoid communication barriers with patients, it is important that physicians use words that are clear, concise and free from significant cultural context; this allows patients to easily decipher the meaning of the words.

Using objective language increases the likelihood that patients will understand intended messages regardless of differences in cultural backgrounds.[4] Consider the following exchange:

> *Patient:* 'Hello Doctor—I am here to find out the result of my CT scan.'
>
> *Doctor:* 'Yes, we received the results of your scan, and not to worry. Everything is A-okay!'

In this scenario, the doctor uses social jargon to convey the positive results of the patient's CT scan. Unfortunately, depending on the patient's background, the actual results of the test may be lost in translation. Consider this rephrasing of the doctor's statement:

> *Doctor:* 'We did receive the results of your scan. I'm happy to report your imaging results show that all your organs look completely normal.'

By using impartial word choice, the doctor provides a fuller understanding of the results of the scan, and the patient can receive the results with greater accuracy.

Second, consider how word choice affects clinical outcomes. The use of positively charged language (eg, using words such as 'calm', 'heal' and 'comfort') has been shown to produce positive outcomes among patients, including decreased anxiety, improved pain scores and less postoperative emesis.[5 6] This is the positive placebo effect. Conversely, the nocebo effect occurs when negative word choice (eg, using words such as 'stick', 'burn' and 'pain') leads to negative outcomes. The potential for application of this principle in medicine is broad and can be duplicated in both inpatient and outpatient settings. Consider the following clinical scenario and rephrasing that follows:

A patient with a laceration agrees to have the laceration repaired with sutures but is afraid of syringes and needles. Unfortunately, anaesthesia is required. To help the patient be as comfortable as possible, which phrasing is preferable?

> a. 'I am going to insert the needle now—you will feel a stick and a burn.'
>
> b. 'I am going to give you some medicine now—you'll begin numbing up within seconds.'

Option (b) is correct—it primes the patient for positive outcomes, including decreased pain and anxiety. In

contrast, the wording in (a) primes patients for negative outcomes. Studies confirm these results.[6] Words do matter.

By being intentional about the words they choose to use, family physicians can protect patients from unintended cultural misunderstandings and can usher patients through unclear journeys; they can enhance patients' experiences by communicating directly and with positive intent (figure 3).

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UNDERSTANDING OTHERS—METAPHOR AND ITS USE IN MEDICINE

Peter Dorward

Metaphor is a powerful tool towards better understanding and healing.

'It's a debt that just gets bigger. Like a bad loan from the happiness bank.'

Today, Margot is talking about cocaine. But we've had this conversation before. Heroin, alcohol, Valium—there are a lot of street drugs around where I work. There are a lot of people looking for a fix.

Margot is thin, wide-eyed, shaky, tired, withdrawing. Her eyes plead.

'I start off just to get a wee bump, but then later I'm feeling even worse, needing more, and then I'm just chasing my tail. And there're always folk happy to give you a wee chucky bag when you're rattling!'

A 'chucky bag' is a loan: of heroin, or cocaine or anything really. It's a common business model. Drug dealers need to keep their clients happy, just like other business owners.

But I liked this line of hers—the bad loan metaphor. Later, I try it out myself, on another patient.

Big Tam needs something for his 'anger management'. Big Tam has issues with alcohol, gambling, cocaine, violence, his past, his future and his personality. He's trembling with rage. He's barely holding it together as he stares hard at me through little pinhole eyes. He wants me to prescribe him more of the Valium a junior doctor in the emergency room gave him the other night, to 'calm him down'.

'I won't prescribe that for you,' I tell Tam. I just won't.

'Why the F not!?' Tam can be pretty intimidating.

'Because valium will make everything worse,' I remark.

Tam's getting angry, 'Raging Bull' angry. I have an emergency response button somewhere. Under my desk, I think.

'If I prescribe this for you, it will work for about a week. Then you won't be able to manage without it. You'll need more. Then stopping will be out of the question. The longer you take it, the worse it gets. It's like…'

Pause. Think.

'It's like a debt. A high interest loan. From the happiness bank.'

Tam pauses. Tam has been in debt most of his adult life. Gambling, drugs, rent. How could he be otherwise? He's been in and out of prison. Tam knows how men, left wild, use debt to coerce and control. He'll have done it himself to others, no doubt. But to my absolute surprise, Tam nods a little.

'So, what *can* you do for me, Doc?'

It's not words nor their attendant facts that make us human. After all, animals communicate. Even computers have a language. Instead, it's our ability to think in terms of unrelated things that makes us special: the power to imagine ourselves, potentially, as other than we are.

Margot compares her cocaine habit—the *tenor* of her metaphor—to a debt. Debt is the metaphor's *vehicle*. Our shared world of mutual understanding—that which connects tenor to vehicle—is the metaphor's *ground*. In this case, the false friend who traps you in crippling, worsening, dependency (figure 4).

A good metaphor is flexible, arresting, immediately and effortlessly understood. It is creative, a little unpredictable.

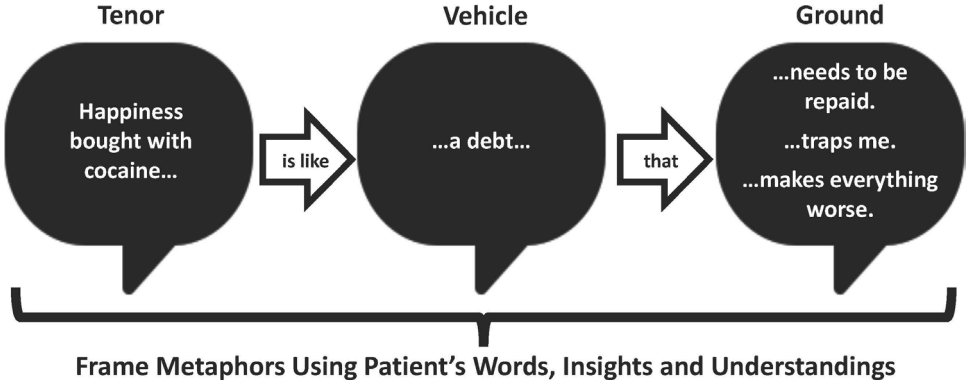

Figure 4 The structure of metaphor.

It is pregnant with meaning, and the meaning is undefined. And metaphor entails risk: we can't always know what powerful change it might produce.

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COMMUNICATING WITH PATIENTS—MAKING GOOD USE OF TIME

Jeanne Cawse-Lucas and Larry Mauksch

Sharing visit planning with patients makes clinical encounters more effective and efficient.

Patients have a lot to discuss with their family doctors: they bring biomedical problems plus complex emotional concerns that accompany their health issues. Unfortunately, not all topics of importance are immediately obvious. Learning how to partner with patients helps family doctors handle these issues, improves quality of care and enhances the experience of patients and physicians.[7]

Physicians name time limitations as one of the biggest challenges in practice.[8] Identifying and addressing key issues can be overwhelming—it is often difficult to sort out what really needs to happen *today*. Adeptly using communication skills can help physicians manage these challenges.[7] Upfront collaborative agenda setting helps organise office visits and decreases the chance that disruptive 'oh, by the way' issues surface late in the visit.[8]

Being curious while eliciting patients' concerns and asking patients to prioritise concerns in order of importance simultaneously helps make visits patient centred and efficient. The first item patients identify is not always the most crucial, and not all concerns need to be addressed in one visit. When possible, postpone listening to the stories behind any concern until you and your patients decide which issues deserve attention first.

Sometimes, patients' concerns are focused on problems. Other times, patients simply need someone to witness their experience and help them make sense of it. Regardless, giving patients space to list all their concerns and then working with them to clarify goals for the visit builds trust. The totality of the patient's list can provide a clue to unnamed issues, such as fear of cancer, family discord, difficulty managing a chronic illness and financial stress.

Collaboratively determining visit goals at the beginning of clinical encounters means proactively planning the use of time. Such planning enables physicians to protect time in the closing moments to create plans that fit with patients' values and resources. Many patients, especially those with limited health literacy, have a hard time understanding and retaining the details of clinical discussions. Shared planning time helps turn words into actions that stick!

The accompanying figure displays two patterns of clinical visits (figure 5).[9] The first demonstrates how interactions without upfront agenda setting result in less recognition of problem importance and more issues raised in the closing moments.[10] The second shows how upfront agenda setting helps organise visit concerns and protects time for action planning.

Watch seasoned physicians work and pay attention to how they manage time. Before agenda setting, do they establish rapport? Do they maintain eye contact? Does their body language convey being rushed or relaxed? Do they express warmth? Do they ask patients to list concerns, or do they dive into the first concern without knowing if other issues are lurking? Observing the words and actions

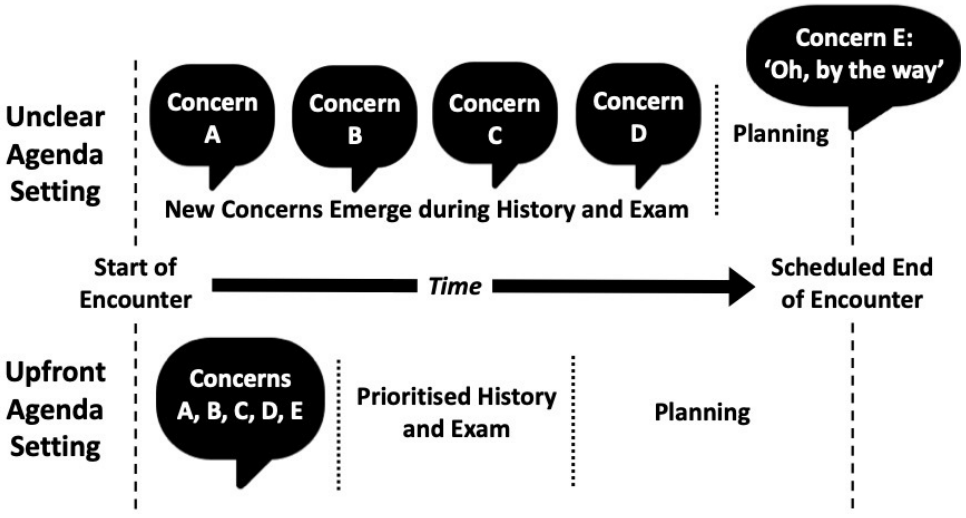

Figure 5 Setting agendas with patients. For additional information, go to the Patient Centered Observation Form (PCOF) online training.[9]

of role models will help you hone your own style to make the most of your time with your patients.

Working collaboratively with patients to plan time together is a set of learnt skills. Dare to share the responsibility of such planning with patients. Learn to understand patients in the context of their lives. You may be pleasantly surprised at the short-term and long-term gains.

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THE PATIENT-CENTRED MEDICAL HOME—ASPIRATIONS FOR THE FUTURE

Autumn Kieber-Emmons and Ben Crabtree

The patient-centred medical home concept: a complex, ongoing vision for excellence in the delivery of primary medical care.

The idea of the patient-centred medical home (PCMH) emerged in the 1960s as a historical aspiration—a nebulous vision to strive for in primary medical care. This aspiration helped stimulate the amazing transformation of family medicine that occurred in just under two generations, with general practice emerging from a cottage craft of lone general practitioners to continually evolving models of care seeking to be more collaborative and transparent (figure 6).

The PCMH concept was endorsed by the major primary care professional organisations and emphasised ongoing relationships between patients and their personal physicians, a team approach to care, a whole person orientation and supports for care integration, quality, safety and access.[11] Unfortunately, we have still not achieved the aspirations of what a PCMH could be due to many pressures acting as countervailing influences shaping what was possible.[12] As the PCMH model further crystallises, we need to imagine a revitalised PCMH that builds on collaboration, relationships, communities, public health and the public good. We must envision a PCMH that is not reduced to the sum of a list of quality metrics.

Federally qualified health centres (FQHCs), situated directly in the neighbourhoods they serve, are leading the way in innovation with emerging PCMH models that marry health and prevention, disease and illness management, and community engagement and public health priorities. These evolving FQHC models succeed when values of teamwork, relationships and collaboration are promoted. In practices across the USA, teams of physicians, nurses, medical assistants, integrated behavioural health professionals, dental practitioners,

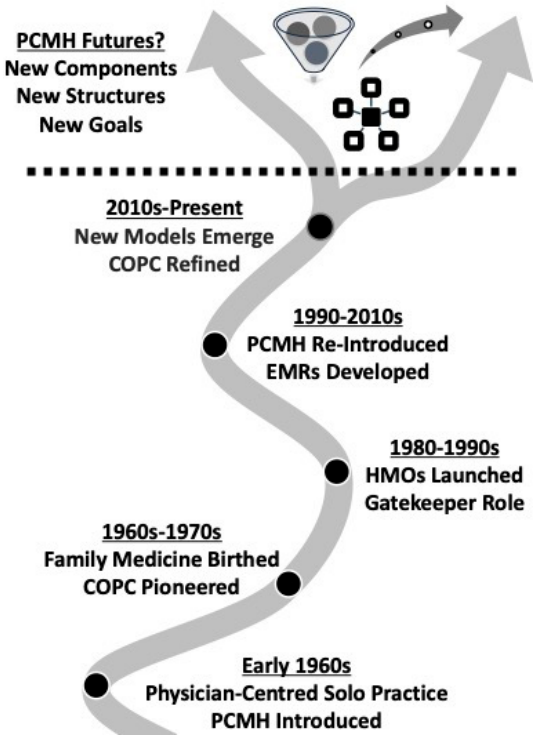

Figure 6 Evolution of the patient-centred medical home (PCMH) in generalist practice. COPC, community-oriented primary care; EMR, electronic medical record; HMO, health maintenance organisation.

social workers and community-based partners all reside in one-stop community wellness centres that focus on what their surrounding communities need for health. Direct primary care (DPC) is another innovation with positive attributes that can be applied to future PCMHs. DPC provides patient-centred and relationship-centred care without constraints of insurance company directives. While medical schools and residencies perpetuate visions of physician captains steering ships and doctors saving the world, the reality of wellness and healing lies less in singular saviours and more in collaborative, life-strengthening partnerships through a new vision of the PCMH.

When family medicine was being birthed from general practice in the USA, Gayle Stephens observed that family medicine was a countercultural movement.[13] We, as the family physicians of today, must persist in holding the belief that positive innovations—advances in components, structures and goals of PCMH—are possible and worth the effort. As we imagine what health, healthcare and healing mean, each one of us has an important role to play in resisting the maelstrom of corporate practice and shaping of the future of primary care medicine. We must be part of a collective reinvention of primary care medicine to achieve the values, practices and ways of knowing consistent with this new vision.

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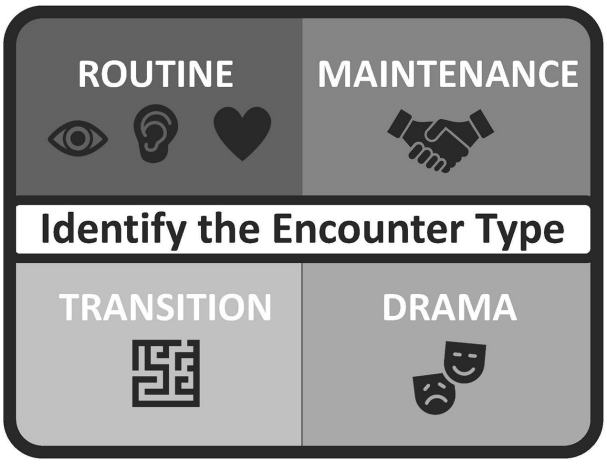

Figure 7 Negotiating the encounter.

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ROUTINE, CEREMONY OR DRAMA?

Will Miller and Veronica Brohm

Family physicians must be master jugglers, dexterously handling adequate access to care, patient relationships, time and personal care. To remain centred, family physicians must determine whether each encounter is a routine, ceremony or drama.

Practising hospitality, a core value of family medicine, means offering everyone an open invitation to healthcare. Offering this invitation, however, can be a challenge: caring for many people generates tension with the commitment to sustain care for each person. Recognising every clinical encounter as either a *routine*, *ceremony* or *drama* eases this tension (figure 7).[14] This recognition occurs early in the encounter while you and your patients collaboratively negotiate visit agendas.[15 16]

Routines sound like a simple melody. There is a single, unpretentious presenting concern that is less than two weeks old—think of an uncomplicated ankle sprain. What you see, hear and feel during routine encounters are congruent; patient communication is clear and direct. Patients hope for a rapid return to normalcy. Keep it a routine visit, stay on time and build patient trust.[17]

Maintenance ceremonies sound like a steady drumbeat. Every visit is like the one before. Chronic illness ceremonies occur when the patients' conditions are relatively stable; they involve persistently nudging patients towards better health and function. Life-cycle ceremonies, including well child, health maintenance, sports examinations and prenatal visits, often rely on protocols and guidelines. Focus on collaborative care and patient self-management, stay on time and build more patient trust.

Transition ceremonies sound like loud, dissonant noise. These are 'schedule busters' where patients present with multiple overlapping, confusing and nearly impossible-to-sort-out concerns. Your inner self flashes red lights. Communication is difficult at best. Don't get into the drama, stay on time and dip into your patients' trust accounts.

In these circumstances, transition towards a future *drama* appointment. To accomplish this transition, save time, protect patients from further harm, and lessen anxiety, practise 'LATE'.

- ***Listen* thoughtfully**—Validate your patients' stories.
- ***Address* your patients' anxieties**—What most frightens and troubles them?
- ***Touch these* frights and troubles, physically and metaphorically**—Use your hand or a ritual object like a stethoscope.
- ***Express* hope**—Co-develop an action plan that builds on the patient's strengths until the next visit.

Dramas sound like opera. These are planned visits for patients struggling with new chronic illness diagnoses or complex health concerns complicated by other factors such as homelessness, addiction, emotional trauma, family struggles and racism.[18] Over time, drama encounters can help you develop symptom, illness and family stories about each patient. In doing so, you can help patients imagine and build healthier lives on their own accord and in collaboration with others,[19] including members of your practice team, consultants, home healthcare workers, family and friends, and other supportive community partners.

A typical family physician's day is filled with multiple kinds of maintenance ceremonies, a few ongoing dramas, a smattering of routines and a couple of transition ceremonies. Developing healthier professional lives means recognising in which category any one clinical encounter 'fits',

whether routine, ceremony or drama, and responding attentively and appropriately, with imagination, compassion and joy, ready to adapt at a moment's notice.[20]

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THE LIFE COURSE

Tim Daaleman and Kelly Bossenbroek Fedoriw

The life course paradigm encompasses a dynamic worldview of persons that extends beyond the family unit by considering individuals' social and environmental settings, providing a way of understanding patients within their contexts over time.

Life course principles include the following[21]:

- Lifelong development and ageing capture a longitudinal, often intergenerational perspective that connects early-life influences with events and outcomes in subsequent years.
- Agency views individuals as active participants who construct their own life course through the choices they make and actions they take, given the opportunities and obstacles that enhance or inhibit their personal circumstances and well-being.
- Historical time and place recognise that individuals are embedded in and shaped by the places that they experience over their lifetimes.
- Timing highlights the developmental antecedents and consequences of behaviour patterns, life events and transitions in people's lives.
- Linked lives represent the network of shared relationships that surround an individual and is more inclusive than the family unit.

Unlike other disciplines, family medicine considers each patient's life course. Rather than viewing each visit as a discrete episode of care, family physicians consider the longitudinal health and illness trajectories and transitions of patients over the course of their entire lives. This orientation enriches contemporary practice and can promote value-based care, population health and the inclusion of social determinants of health.

Innovative service models informed by the life course are grounded in a longitudinal delivery of care, with a focus on minimising developmental risks, optimising healthy outcomes and integrating medical and community-based services across different stages of patients' lives.[22] From a population health perspective, integrating a life course paradigm helps clinicians generate comprehensive health data that document patients' trajectories and transitions by mapping sequences of health and illness over time. In addition, this approach also accounts for place effects—characteristics of the social and physical environment—by capturing and understanding features of the local environment that influence health and healthcare.

Figure 8 The life course: humanising healthcare. Copyright 2021 UNC-Chapel Hill. Adapted with permission.[27]

Life course physicians occupy a central role in healthcare systems by using their contextual knowledge of patients to outline and guide care options.[23] A life course orientation also advances family medicine research, placing it at the forefront of translational and multilevel initiatives, where organising and integrating individual, organisational and larger social determinants of health require a longitudinal socioecological framework.[24 25]

The intellectual history of family medicine is rooted in a commitment to people rather than to a defined body of knowledge. Today's family physicians require a way of thinking about patients that conceptualises, integrates and ultimately humanises their health and illness experiences within the context of the larger healthcare and social environment. The life course paradigm responds to this gap by focusing on the intersection of patients' biographical and social lives, providing an organising framework to advance the work of family medicine (figure 8).[26 27]

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