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TEACHING EXCHANGE

Improving patient–doctor communication through the use of 'receipts'

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Introduction

Let's look at the following example of a patient/doctor consultation:

Patient I have had such a terrible cough
Doctor Hmm
Patient I have had such a terrible cough! (Vigorous cough)
Doctor Hmm
Patient I have had such a horrible cough; I can hardly catch my breath. (Coughing more loudly)
Doctor Hmm
Patient I've had such a horrible cough; I can hardly catch my breath. I think I'm going to choke! (Coughing even louder)
Doctor Hmm

This was the opening of a role play at a 1997 consultation course in Kalymnos, Greece [1,2]. During the consultation, the patient describes his symptoms and expresses his feelings using stronger and stronger phrases. As he receives no acknowledgement from the doctor, he consequently repeats the description of his symptoms with more emphasis [3]. The doctor misses an empathic opportunity [3,4]. Had the patient's symptom description elicited a 'receipt' from the doctor, it is possible that the patient would not have felt the need to repeat it four times. A receipt could be a simple statement like 'That sounds really unpleasant'. This responds to the feeling the patient expresses and provides the patient with an affirmation, or receipt, that the doctor has understood his situation.

In the literature, receipts are considered to have the function of expressing friendliness, solidarity, agreement and attention [5,6] and releasing tension. Receipts have also been described as empathic responses to patient clues [3,4], interactional response tokens [7] and acknowledgement tokens [8].

During the courses on Kalymnos, thousands of consultations have been filmed and subsequently analysed by teachers and participants. In this consultation 'laboratory', by acting as their own patient in role play with a colleague, a doctor can become his or her own 'golden standard' and can judge whether the receipt they received is sufficient to feel understood. In this way, various forms of receipts have evolved over the years. As our tool for teaching, we separate the consultation into three parts and use the 'five card method' in the Patient Part [9] Figure 1.

Prior to the consultation

Prior to consulting a doctor, a patient has often built up a complex story around their presenting complaint, the magnitude of which the patient themselves may not be aware. The patient's presenting complaint occurs against a multi-faceted background of emotional reactions of which some are almost always negative such as inferiority, pain, shame and guilt. To be confronted with existential questions, feelings of loneliness, meaninglessness, fear of death and loss of freedom raise anxiety [10].

This situation has many similarities with the mother–child relationship, the patient wanting to meet a kind, strong and wise professional, who is accessible, responsive and engaged, a safe haven against life's troubles [11,12]. The patient meets the doctor with a focused, concentrated attention – sometimes, the consultation is literally a matter of life or death. This means that the patient's attention and perceptiveness can become very selective and they may exhibit rigid black-and-white thinking. Such heightened perception in the Patient Part can ensure that even the first few seconds of the consultation can be decisive for the success of the consultation as a whole [13].

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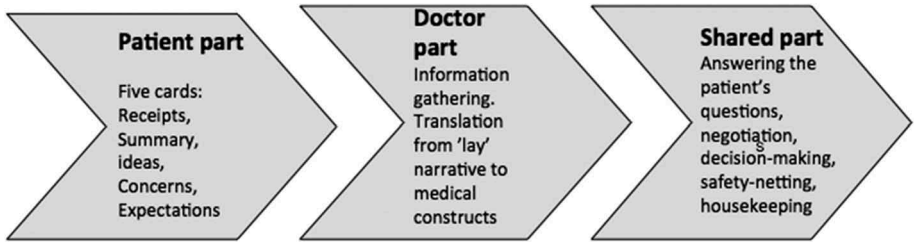

Figure 1. The three parts of the consultation and the five cards in the Patient Part.

Bridging the gap

In what we call the Patient Part of the consultation, the patient enters the consultation room and starts to speak [2]. Whilst welcoming the patient and asking him or her to sit and tell their story, a note can be made of facial expressions, posture, pace etc. and the mood in the room can be observed. In the introductory example about a cough, the patient expresses his feelings by describing the cough as 'awful'. The use of the loaded adjective 'awful' relays both unpleasant sensations, thoughts of what the cough may represent, fears of worsening health and the desire for help to get better. There is a subtext to the patient's choice of words, which says 'Doctor, will you listen to me? Do you understand me and accept me? Will you help me?' It is an implicit request for help. How can we bridge the gap between what is actually said during the symptom presentation and the implicit request?

When the doctor is attentive and gives the patient a receipt, e.g. 'It's good that you came', the patient immediately understands 'the doctor is going to help me'. This means that he has come to a safe haven and can continue to explain his thoughts, worries and wishes. With just a few words, the patient feels reassured that the message has got through – the gap has been bridged [6].

If the doctor gives minimal verbal responses like 'hmm' in the conversation above, sooner or later the patient will wonder if his message has actually got through and may start to feel a growing insecurity: 'Does the doctor understand?' 'Is he going to help me?' If the receipt is insufficient, the patient will repeat his assertions and maybe reinforce them (as in the example). If doctors ask typical medical questions like 'when did it start?' or 'where is the pain?', the patient's unspoken questions are met only by the doctor's medical questions. So instead of receiving an answer, a question is greeted by another question. This will widen the gap between patient and doctor.

How to find the right receipts – the role of emotions in consultation

Usually, the patient's narrative will itself evoke feelings in the doctor. A statement like 'I have such a terrible pain in my throat (back/knee/head)' could either allow the doctor to put themselves in the patient's position and try to feel what it is like to be the patient or – on a busy day – trigger the doctor to rush into diagnosing and problem-solving thus entering the Doctor Part of the consultation. To avoid getting overwhelmed by emotions from the patient, the doctor can give a receipt. Verbalising feelings allows them to be processed more easily. This can free both the patient and doctor from a pervading emotion and lead the consultation forward by increasing the sense of security within the interaction. This increases the possibility of the patient being able to deliver a true version of their situation without delay. After all, the patient is the 'key informant'.

Patients often evoke strong feelings in doctors. Doctors react emotionally to patient's personalities and appearances. They feel stressed by demanding patients, get swept along with the anxious, turn sad and tired with the depressed, get angry with the angry, get struck by powerlessness with the chronic pain patient etc. In many situations, the patients' feelings rub off on the doctor. When the doctor understands that what he or she perceives as their own feelings may actually reflect how the patient is feeling, it can assist in selecting an appropriate receipt. By saying 'Your situation sounds very tiresome/annoying/lonely/stressful/sad', the doctor shows that they have understood how the patient is – probably – feeling, and both parties can relax a bit more in each other's company.

On the other hand, if the emotions the patient brings with them to the consultation are not addressed, they impact negatively on the consultation and become an additional source of stress for both parties. As in the example of the patient with a cough, the patient's negative feelings were enhanced

when the doctor did not acknowledge them. The patient's dissatisfaction rubs off on the doctor. Sometimes, a patient just needs to say a phrase such as 'I need a referral for an MRI-scan' to activate the doctor's defences. How, in that situation, can the doctor preserve a non-judgemental, interested position? This is where the use of receipts can create a connection to the patient, where, by temporarily 'going along' with the patient's request, the doctor neither interrupts nor interferes with the patient's account, for example 'Thank you for letting me know what you want. Tell me a little more'.

The successful use of receipts helps the patient to feel that a rapport is established, their visit to the doctor is legitimate and the atmosphere is conducive to continuing their explanation. Typically, receipts enable the patient to venture to express views that may be particularly significant, strange, embarrassing or worrying. Thus, receipts assist the doctor to individualise the consultation and meet the patient's specific need. In this way, mutual trust can be established [14].

Conversely, the patient who does not receive receipts often feels dissatisfied and can experience feelings of loneliness, shame and frustration. This patient may leave the consultation with a double sense of shame, first in relation to having needed to seek medical attention in the first place and second by having failed to gain the understanding of the doctor [15]. Aggressive patients can be disarmed by the use of receipts like 'Thank you for telling me that', 'I'm glad you came' or 'I will certainly try to help you'. These strategies can be trained in doctor/patient roleplays before applying them in real life situations. See Table 1.

Table 1. Types of receipts.

Receipts that express listening are any verbal or non-verbal response that shows that the doctor is attentive and listening. It includes nodding, eye contact, facial expressions and short verbal cues like 'ok', 'mmn' and 'yes'.
Reflective receipts mirror the emotional content of what the patient has shared and encourage empathy. Naming feelings reveal the emotional agenda.
'It sounds annoying, that recurrent stomach pain of yours'.
'I see you are sad/tired/angry/irritated/optimistic/in pain'.
'That must have been tough on you'.
Validating receipts confirm the appropriateness of the patient's emotions and reactions and legitimise the patient's decision to seek help
'I'm glad that you came to see me'.
'It is quite common/normal/human to react like that'.
'In a situation like yours I think most people would react in a similar way'.
'No wonder you think/feel like that after all you have been through'.
Receipts that express care, concern and respect for the patient emphasise the individual doctor's unique relationship to the patient and are delivered in the first person
'I want to help you'.
'I'm sorry that you had to wait for me'.
'Thank you for telling me! I'm glad to hear that you are feeling better etc.'.
Appreciative receipts reduce feelings of shame and inferiority through recognition or praise and encourage the patient to express the full extent of their agenda
'Well done! Good that you tried, I'll try to help you the best I can'.
'I can see that you are a responsible person who takes your health seriously'.
'You really know how to express and formulate what you experience. It makes it easier for me to understand what is happening to you'.
Inviting receipts encourage the patient to speak more and address the patient's often subtle cues that they have more to tell
'Thank you! Tell me a little more, perhaps about your thoughts and worries'.
'Now I know a little more about what you want/wish/think. This sounds important, tell me more'.
'I'll certainly try to help you. I wonder what kind of help you would like?'
'Please tell me all you think I need to know'.

The Patient Part of the consultation and the three cards belonging to the patient in the 'five card method'

In the first part of the consultation, *the patient's feelings and reflections rather than symptoms* will provide an understanding of the patient's mind set, and thus the core of the patient's request. As soon as the patient mentions symptoms – in an attempt to legitimise the visit – the doctor's medical mind automatically starts forming hypotheses as to what is wrong with the patient. This line of thought activates the doctors desire to solve the problem and the urge to ask the patient questions in order to confirm a diagnosis, thus entering the Doctor Part of the consultation. In starting to ask questions about symptoms, the doctor is listening more strongly to their own signals than to the patient's. The patient is often complicit in this and also becomes more responsive to the doctor's signals than to their own signals. The patient tries to answer the doctor's questions, answers generate follow-up questions and the doctor comes to dominate the conversation and begins a cross-examination. To avoid this cross-examination situation and to establish empathy, the doctor must learn to linger a while in the Patient Part of the consultation. Receipts are the best tools for doing so because they make the patient feel that they are seen, heard, accepted and approved. To be able to give receipts, the doctor's mind needs to dwell on how the patient is feeling rather than problem-solving. Contrary to many doctors' beliefs, most patients are able to present the core matter of their visit either within their first sentence or during 30–90 s of uninterrupted speech [16]. To resist the temptation to ask questions initially, it can be helpful for the doctor to remind himself or herself that the patient has to fill their symptoms with meaning in order to be medically intelligible – heartache can after all refer to the fallout after a love affair or a myocardial

infarct. Whilst the patient presents their narrative, the doctor gives receipts and tries to identify the patient's three cards, which we call thoughts, worries and wishes. If the patient does not spontaneously reveal all their cards, the doctor needs to explore further and probably ask some questions. Before asking questions it is none the less more effective to use receipts. Table 2 illustrates *the difference between asking without and with a receipt*. When the doctor understands more of the context and meaning of what the patient experiences, they will be able to understand why the patient has come and it will become easier for them to empathise with the patient.

When asked questions about sensitive material, patients need to feel safety and trust as these questions can otherwise be experienced as threatening and invasive. Blunt questions delivered without prior receipts can make the patient wary because:

- questions often imply an underlying statement;
- the patient has to reflect before answering (and have their thoughts interrupted);
- the questioner controls the dialogue: when you ask questions, you will only get answers [17];
- a patient may take a question to imply that the doctor doubts her statement or
- the patient tries to determine the motive behind the question which raises issues of trust.

Table 2. The three cards of the patient.

Card 1: Thought (ideas)
What are your own thoughts?
Or: *That sounds difficult (sad, worrying). What do you think about what is happening to you?*
Card 2: Worry (concerns)
What are you worried about?
Or: *So you think it could be the heart. That sounds scary. What do you think this could mean?*
Card 3: Wish (expectations)
What do you want my help with today?
Or: *I would like to try to help you. Anything in particular you thought I could help with today?*

Medical questions are of course subsequently an essential part of the consultation but we can rely on the closer verbal and physical exploration of symptoms that belong in the Doctor Part of the consultation [1,2,4].

Will things take longer if the doctor uses receipts?

The use of receipts is also important for the doctor's well-being. As long as the doctor has failed to verbally acknowledge the patient's feelings, the doctor remains burdened by those feelings and the situation can become more and more onerous. By expressing some of the feelings verbally, they can be addressed leading to at sense of connectedness [3,18].

In the consultation, there are many tasks to accomplish within a limited period of time. Empathising, giving receipts and thus calling forth more of the patient's narrative may at first seem counterproductive. However, getting closer to the core of the patient's visit saves time by improving the efficiency of history taking, diagnostics, negotiation, treatment and compliance. Decreasing the patient's stress allows the patient to listen better and the patient's satisfaction calms the doctor. Both parties are able to think more clearly and the doctor experience greater job satisfaction and is less drained.

Giving receipts can also be detoxifying as it can help the doctor to avoid being influenced by the patient's negative feelings for example frustrations about the course of an illness, waiting times, other doctors etc. If the doctor confirms that complaints have been heard, it shows that the reasons behind the frustration have been understood and if necessary proceed to apologise, then discussions and possibly disagreements can be avoided and both doctor and patient can proceed quickly to the patients current complaint.

It has been observed that after attending a course in this method, doctors find that their patients are more satisfied and less 'difficult', and they themselves are more satisfied and less tired when coming home after work [19]. When doctors review their own consultations on video, they are often able to see how and when they could have relieved the tension by giving more receipts.

The power of summarising

One effective way of delivering receipts is in the context of a summary. By summarising back to the patient what has been said, the patient receives a powerful confirmation that they have actually been listened to. Both parties engage cognitively with the summary to verify its accuracy. Perhaps, the patient will complement with additional information, thus clarifying the situation further. It is calming for patients to know what the doctor has understood their situation and the summary may have therapeutic potential in its own right:

'You got a tightness in your chest, your colleagues were upset, called an ambulance, and at the hospital you were thoroughly examined and treated.... Many people in that situation would be afraid of dying, but maybe that didn't cross your mind?'

The phrase starting 'Many people....' opens a permissible space for the patient to express fears. The summary

helps maintain structure and an overview of the conversation, partially by allowing the doctor to touch base with their cognitive self.

Conclusion

Receipts are effective consultation tools for doctors to establish and maintain relationships with patients, to acknowledge and share feelings and to reduce tension and the need for disruptive questioning. When the patient feels he has been listened to and acknowledged, the consultation also becomes more rewarding for the doctor.

Receipts answer the hidden questions that are the unspoken subtext of what the patient actually verbalises when presenting their problems. Receipts pave the way, allowing the patient to express their reflections and possibly idiosyncratic ideas or worries. In a context of safety and trust, thoughts, worries and wishes are often expressed spontaneously. If this happens, the doctor is wise to accept the proffered information and give a receipt. If more needs to be explored, it is often appropriate to begin by summarising and confirming what the patient has shared so far.

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