The Construction of Physician-patient Trust

A Case Report of an Oncologist's Consults in Palliative Care

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Abstract

The term bioethics generally refers to the study of the ways in which science and more particularly medicine influence our lives and our environment. It is fundamentally concerned with issues relating to the beginning and the end of human lives. This contribution describes an analysis of medical discourse in a palliative context, and more in particular it shows how trust is constructed between an oncologist and his terminal patients during follow-up visits in the academic hospital of Nijmegen in the Netherlands.

Keywords: bioethics; palliative care; physician-patient communication; trust.

1. Introduction

1.1. *Palliative care, ethics and communication*

The World Health Organization defines palliative care as follows:

> Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. [1]

[1] http://www.who.int/cancer/palliative/definition/en/.

Paulus (2008) considers palliative care to be an ethical obligation, since it improves the quality of life of patients with an incurable disease in accordance with their values. Consequently, it is important that the medical personnel is aware of the values, norms and wishes of the patient. Besides for example well-co-ordinated care and respect, important aspects of a successful palliative care process are a good relationship between patients and their physician(s) and open and efficient physician-patient communication. Studies have shown that communication is frequently a major problem in medical consults. Research by Plonk and Arnold (2005), for example, has shown that 50% of the family members of patients deceased in a hospital considered communication to be a problem. According to Mistiaen and Francke (2004), adequate information does help: patients feel less frightened and less confused. It is essential to provide information more than once and to use different communication channels. A similar statement is made in report 115C of the Belgian Health Care Knowledge Centre.

> Communication with patients and families at the end of life is very important. The literature about needs concluded to the need for stepwise delivered information and for sensitive communication with patients and their informal carers. Clear communication with the patient is not only beneficial for the palliative patient and his/her family but as well for the wellbeing of the caregiver. (Keirse *et al.* 2009, 93)

1.2. *The importance of trust*

Trust has been defined in various ways and from different perspectives. In general, trust is described as the "accepted vulnerability to another's possible but not expected ill will (or lack of good will)" (Baier 1986, 235). The importance of trust in society is indisputable. Illingworth (2002) quotes Bok (1978, 41):

> [t]rust is a social good to be protected just as much as the air we breathe or the water we drink. When it is damaged, the community as a whole suffers and when it is destroyed, societies falter and collapse. (Bock 1978 in Illingworth 2002, 35)

Thom *et al.* (2002) discuss why trust is of such high importance in medical interactions. When trust is lacking, patients, on the one hand, ask for a second opinion, more tests, referrals and extra medical information [2]. Phy-

[2] It would be interesting to research if lack of trust increases the use of the Internet for medical information by patients.

sicians, on the other hand, are more likely to ignore the patient's questions if they suspect that those questions are based on a lack of trust. This is in line with Gopichandran and Chetlapalli's conclusion (2013, 1): "Trust is known to improve the clinical outcomes".

Several authors confirm that communication plays an important role in trust. Fiscella *et al*. (2004, 1049) for example claim that "[p]hysician verbal behavior during an S[tandardized]P[atient] encounter is associated with trust reported by SPs and patients". Open communication is one of the trust inducing factors discussed by Pearson and Raeke (2000)[3]. In their research, Tarrant *et al*. (2010) compared single-episode consults and repeated interactions. One of their conclusions is that patients consider trust to be part of a stable relationship with their physician.

2. Research material and methodology

In February 2010, twelve consults with a male oncologist in palliative care were audiotaped with the patients' consent. The oncologist, who has over thirty years of experience, is considered by his peers to be a model of patient interaction. The total length of the recordings is 3 hours 15 minutes; the average length of the consults is 16 minutes and 27 seconds. The recorder was switched off when the physical examination started. The consults, that are all in Dutch, were transcribed *verbatim*[4] and analysed by both researchers using a bottom-up discourse analysis methodology, starting from the material itself instead of a (theoretical) model.

> In a bottom-up approach, the lexical and/or form-focused corpus analysis comes first, and the discourse unit types emerge from the corpus patterns. (Upton and Cohen 2009, 585)

As, for example, Yang (2012, 2) states, a bottom-up analysis is more specific and more efficient when "the discourse structures are unpredictable and variable in a wide range".

The transcripts contain approximately 32,000 words (19,000 spoken by the oncologist, 13,000 by the patients). All twelve consults are follow-up visits, which is relevant in an analysis of trust (cf. Tarrant *et al*. 2011).

[3] The others are competence, compassion, privacy and confidentiality, and reliability and dependability.

[4] Prosodic features are usually part of transcripts for research in the domain of conversation analysis. Since that is not the theoretical background of this study, they were not included in the transcripts of the research material.

For the analysis of the material the Four Sides model of Schulz von Thun (1981, *Figure 1*) is used[5]. In every message four aspects are identified: self-revelation (of the sender), factual information, appeal (to the receiver) and the relationship between the sender and the receiver. They are discussed separately and their role in constructing trust in a physician-patient relationship is illustrated.

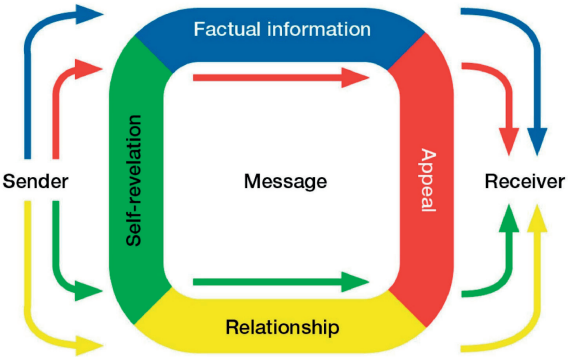

Figure 1. – Four Sides model (Schulz von Thun 1981).

3. Results

First (3.1), the different elements of the Four Sides model are discussed in a general way, indicating their link with trust in the relationship between the patient and the oncologist. Some of them contribute to the construction of trust, others are proof of that trust. Examples of the various elements are given in section 3.2, in which one particular case is discussed in detail.

3.1. *General discussion*

3.1.1. Self-revelation of the physician

During the consults, the physician takes on different roles: he is a medical expert, a discourse organizer, a (psychological, legal, financial etc.) advisor and

[5] The oncologists participating in the project agreed that this model suited the research and was comprehensible to non-linguists.

a confidant. Not only does each frame contribute to trust building, but also the ease with which the physician easily switches from one frame to another adds to the construction of trust. Since it shows empathy and expertise, it develops patients' trust. At the same time, while taking up all those roles, the physician remains a 'real' human being who connects with his patients.

Self-evidently, trust increases if the physician shows his competence not only as an oncologist but also as a member of the larger medical community. If the physician succeeds in organizing the discourse by steering the interaction, by adding structure, by including discourse markers etc., this shows the patient that he is well informed about the situation and the medical history. If the physician is capable of giving relevant non-medical (legal, social, financial, etc.) advice to the patient, he is more likely to be considered as a knowledgeable and thus trustworthy person.

While the frames described above induce trust between the patient and the physician, the role of confidant proves it. People confide in another person if they trust them and are confident that the information will be treated in a respectful manner.

3.1.2. Factual information

During the consult the physician provides the patients with general and patient-specific medical information. If he presents that information clearly and comprehensibly, this again shows his (communicative) competence, which increases the feeling of trust.

The physician's communicative competence is also shown in the way he structures the consult (cf. discourse organizer frame). He respects the standard structure of a medical consult (general information, specific details, synthesis, additional questions, physical examination). If the conversation deviates from that structure, he takes corrective measures but he always respects the patients by taking their questions into account.

3.1.3. Appeal to the patient

The physician gives direct and indirect instructions to the patients. The fact that those instructions do not only pertain to the treatment but also to the patients' personal life, shows that the physician is well aware of the patients' situation and has a personal relationship with them. Gopichandran and Chetlapalli (2013) conclude that personal involvement is a factor influencing the patient's trust. The patients interviewed by Tarrant *et al.* (2010) mention personal knowledge as an element on which they base their trust.

3.1.4. Physician-patient relationship

Schulz von Thun (1981) has described the relational aspects of communication in a more detail (*Figure 2*). Communicative behaviour is placed on two axes: contempt ↔ appreciation and patronizing ↔ giving autonomy.

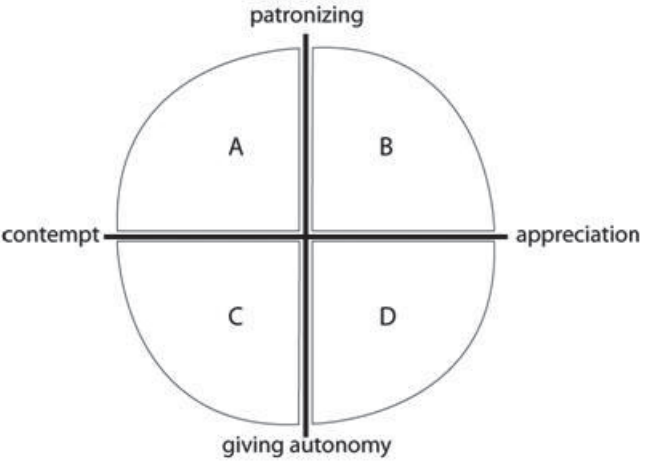

Figure 2. – The relational aspects of communication.

The most salient attitudes of the physician in these consults are integrity, honesty, affirmation, admiration, respect, encouragement, compassion etc. The majority of those attitudes, which are evidently linked with the roles he takes up, are situated in quadrants B and D. For example, encouragement and compassion are appreciative and compassionate attitudes (B), honesty and respect show appreciation and respect (D).

Those attitudes are evidence of an empathetic person. Empathy enables people to know and understand someone else and to react appropriately to that person (Leijssen 2004). That empathy is important in a physician-patient relationship has been extensively discussed in literature. Leijssen (2004, 1) for instance describes empathy as "een basisvaardigheid in de menselijke omgang waarvan de waarde onomstotelijk bewezen is in de medische praktijk"[6]. She distinguishes four levels of empathy in medical consults: giving attention to what patients say, making hidden ideas and

[6] "[A] basic skill in human interaction of which the importance in medical practice has been conclusively proven" (our translation).

feelings explicit, uncovering the less obvious and revealing new meanings. The material contains several communicative procedures that illustrate the levels of empathy. For example, the physician paraphrases and interprets the patients' utterances to indicate that he fully understands what they are saying both overtly and between the lines.

The material also contains several humorous interactions. That humour is acceptable in end-of-life situations is proof of a good relationship. The humour in the consults can be considered as affiliate humour (Martin *et al.* 2003) which strengthens the relationship between the interlocutors. Bos (2010) states that that kind of linking humour is introduced to improve the relationship with others in a relatively harmless and self-accepting way. According to relief theory humour eases (physiological) tension (Meyer 2000).

3.2. *Discussion of one particular case study*

3.2.1. Description of the case

To illustrate the general conclusions of the analysis (3.1), case 11 of the corpus material (6,424 words) is discussed in more detail. The patient is a woman in her mid-40s. She has a daughter, who is a university student in a distant town. The patient has breast cancer, metastasized to the lungs and the lymphatic system. Her life expectancy is two to four months. The transcribed follow-up visit takes place after an operation to remove fluids from the lungs. Before the visit she had an X-ray of her lungs. One of the main topics of the conversation is an experiment that the patient decided to perform on her own: as she wanted to know how ill she really was, she stopped taking her medicines for a while. The result was very bad. Consequently, she understands the severity of her disease and asks the oncologist how much time she has left and how she will die. It also becomes clear that she worries about her daughter and that she is figuring out how she can explain to her daughter her dying in the near future.

3.2.2. Examples

First, we illustrate some of the different roles the oncologist takes on. It goes without saying that he continuously shows himself as a medical expert. Example [7] (1) illustrates not only that role but also the one of dis-

[7] The examples are our translations of the transcript.

course organizer: he uses meta-discourse elements to structure the consult (frame markers) and he indicates the order in which he will discuss the patient's questions.

(1) One of the reasons is that I am worried that the cells will get fixed in the lymphatic vessels of the lung. [...] That is one reason. [...] But there is also a second reason to give you Dexamithazon and that is because you were feeling nauseous. [...] And there is a third reason to give you Dexamithazon, because everything makes you so tired. [...] So it's situated on three levels.

He also acts as a psychologist giving honest information about the progression of the disease, but he avoids terrifying answers to protect the patient. So he shows the 'benefits' of the treatment and stresses the positive aspects (example 2). At the same time he compliments the patient on her courage (example 3).

(2) The illness itself, the malignant disease, the breast cancer, continues but you have more comfort.

(3) You are a wonderful person.

Because he includes positive elements, he succeeds – in spite of the difficult situation – to create a rather relaxed feel-good atmosphere. There are several linguistic elements that realise such a positive atmosphere (Heynderickx and Dieltjens 2004), such as the use of words with a positive meaning, enumerations, diminutives, strategic negations, etc. For example, the physician regularly uses *wat* (some) en *een beetje* (a little bit) (examples 4, 5). Example (6) shows his use of negations.

(4) We hadden het er al een beetje over gehad, he. (We've already discussed this a little bit.)

(5) Kijk, dan zie je precies wat de longarts zegt. Hier zie je nog wat grijs, dat komt deels omdat het hart daar ligt, deels omdat er een beetje vocht zit. (Have a look, you'll see exactly what the lung specialist says. There is some grey here, because the heart is positioned there, but also because there is a little bit of fluid.)

(6) En ik ben er niet bezorgd rond, het heeft geen andere betekenis voor de toekomst. (I am not worried about it, it has no extra meaning for the future.)

Another striking aspect in the oncologist's discourse is the fact that he does not avoid future-oriented statements although the situation is futureless (example 7).

(7) Can I help you to enjoy every day more than what your illness normally allows?

The consult frequently contains interactions that show the empathetic attitude of the oncologist. For example, when the patient wants to know how much time she has left and how she will die, he paraphrases and interprets her words (example 8).

(8) Yes. I think it's a clear question and I hear in fact two questions. I hear how much time and also briefly and softly how. I don't think you want an answer to the second question. [...] Honestly, the bad news is that I really don't know. I cannot say it for you individually, only in general for groups of patients.

3.2.3. Conclusions of the case

The main characteristics of the oncologist, which can also be found in the other cases, are that he is at the same time a competent physician, an efficient organizer of the consult and an empathetic human being. Those features strengthen the trust of the patients in their oncologist. Indeed, from listening to the recordings and analysing the transcripts it becomes clear that the patients do not doubt his advice. That goes for both the medical and the personal advice. Not a single patient left the conversation feeling sad or discouraged. His colleagues consider this oncologist's communication and interactions with patients as an example for younger physicians.

4. General conclusions and discussion

Bioethical issues are often related to medical decisions regarding life and death. Those decisions (e.g. the chosen treatment, palliative care, euthanasia) are taken by patients in consultation with their families, their physician and other medical personnel. It is of the utmost importance that discussions of such an importance take place in a climate of confidence: the patients need to trust that the physician will advise them on the best course to take.

In this paper an overview of twelve follow-up visits in palliative context was presented, focussing on one of them as an exemplary case. It was demonstrated how the oncologist presents himself as a trustworthy person: he shows his medical, communicative and social competence, and his personal

characteristics, such as his empathetic attitude, add to the trust building. Some linguistic strategies that create trust were illustrated.

Hyde and King (2010) state that we can only get a full grip on the complex matter of society and bioethics if different groups of society join forces. They refer to policymakers, scholars, scientists and the public. This paper has shown that also discourse analysis and applied linguistics can contribute to this discussion.

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