



# Communication skills in disorders of gut-brain interaction

Douglas A. Drossman<sup>1,2,3\*</sup> and Johannah Ruddy<sup>2,3</sup>

<sup>1</sup>Center for Functional GI and Motility Disorders, University of North Carolina, Drossman Gastroenterology; <sup>2</sup>Center for Education and Practice of Biopsychosocial Care, Chapel Hill; <sup>3</sup>Rome Foundation, Chapel Hill, Raleigh, North Carolina, USA

## ABSTRACT

Changes in Western Healthcare have raised challenges to the patient-provider relationship (PPR). Clinicians are faced with pressures to see patients in less time due to lower reimbursement for services and increased administrative tasks like the electronic medical record. As a result, the medical interview and physical examination are becoming abbreviated and the value of the PPR is diminished. Now there is less patient and provider satisfaction and loss of meaningfulness in the interaction. This difficulty is particularly a problem for patients with disorders of gut-brain interaction, where perhaps due to time pressure, clinicians give them lower priority than for patients with acute or structural illness. In turn, patients experience a diminution in their role in the relationship and feel frustrated, less connected to their providers, and at times, feel stigmatized. We propose that proper attention to communication skills that improve patient-centered care will reverse these factors. The result would be clinical visits that are more informative, and time-efficient and optimization of the PPR. This paper: (1) discusses the issues leading to clinical and societal factors that interfere with the PPR, (2) provides the rationale for learning communication skills to improve the PPR, and (3) offers strategies and guidelines to help the clinician re-establish the clinical skills to improve the PPR. (NeuroGastroLatam Rev. 2019;3(2):105-118)

Corresponding author: Douglas A. Drossman, [drossman@med.unc.edu](mailto:drossman@med.unc.edu)

**Key words:** Communication skills. Patient-provider relationship. Patient-centered care. Disorders of gut-brain interaction. Irritable bowel syndrome.

## Correspondence:

\*Douglas A. Drossman

Center for Education and Practice of Biopsychosocial Care

Center for Functional GI and Motility Disorders, University of North Carolina

Drossman Gastroenterology

North Carolina, United States

E-mail: [drossman@med.unc.edu](mailto:drossman@med.unc.edu)

Received in original form: 28-10-2019

Accepted in final form: 30-10-2019

DOI: 10.24875/NGL.19000050

**RESUMEN**

En Occidente, los cambios en el sistema de cuidado de la salud han planteado desafíos a la relación paciente-proveedor (RPP). Los médicos se enfrentan a presiones para ver a los pacientes en menos tiempo debido al menor reembolso de los servicios y al aumento de las tareas administrativas, como la historia clínica electrónica. Como resultado, la entrevista médica y el examen físico se abrevian y el valor de la RPP disminuye. Ahora hay menos satisfacción del paciente y del proveedor y una pérdida del sentido de interacción. Esta dificultad es particularmente un problema para los pacientes con trastornos de la interacción intestino-cerebro, donde tal vez, debido a la presión del tiempo, los médicos les dan menor prioridad que a los pacientes con enfermedades agudas o estructurales. A su vez, los pacientes experimentan una disminución en su papel en la relación y se sienten frustrados, menos conectados con sus proveedores y, a veces, se sienten estigmatizados. Proponemos que el mantener adecuadas habilidades de comunicación centradas en la atención del paciente, reviertan estos factores. El resultado serían visitas clínicas más informativas, eficientes en el tiempo y la optimización de la RPP. Este artículo discute: (1) los problemas que conducen a factores clínicos y sociales que interfieren con el RPP; (2) proporciona los fundamentos para aprender habilidades de comunicación para mejorar el RPP y, (3) ofrece estrategias y pautas para ayudar al clínico a restablecer las habilidades clínicas para mejorar el RPP.

**Palabras clave:** Habilidades de comunicación. Relación paciente-proveedor. Atención centrada en el paciente. Trastornos de la interacción intestino-cerebro. Síndrome del intestino irritable.

Changes in our health-care system have led to a deterioration in the patient-provider relationship (PPR)<sup>1</sup>. For the clinician, increased administrative tasks and certification requirements, along with pressures to see more patients have reduced clinic visit time. In response, clinicians now may order endoscopy and imaging studies as a substitute for face to face visits to save time and possibly to generate more income. As a result, the medical interview has become abbreviated, the physical examination is disappearing, and the quality of the interaction is diminishing. In the end, the PPR suffers. To the clinician, a poor PPR leads to less ability to gather relevant

information, to understand the context of the illness, and to address patient needs. Satisfaction and meaningfulness in caring for patients suffer, and possibly there is increased risk for burnout. Clinicians may then develop negative attitudes and behaviors toward patients, particularly for patients with disorders of gut-brain interaction (DGBI), because these disorders having no structural (“organic”) features are often considered “second class” disorders. As a result, these patients experience a diminished role in the relationship and respond to such negative clinician behaviors with a lack of connection, frustration, and at times self-blame and stigmatization.

To reverse this downward trend, we need to increase the knowledge and skills to optimally communicate with patients to enhance the PPR. For decades one of the authors (DAD), a gastroenterologist, has taught communication skills to help clinicians improve the acquisition of meaningful clinical information in a time-efficient manner and improves the PPR. The second author (JR) as a patient and patient advocate has developed the resources and skills to publish and teach patients and providers the patient experience. This paper will: (1) address the rationale for gaining competence in communication skills to improve patient and provider satisfaction, (2) provide methods and techniques that can be applied to achieve patients centered care, and (3) offer tips and techniques for the patient to benefit their interaction with providers and to gain skills in self-management.

## **ISSUES INTERFERING WITH THE PPR IN MODERN MEDICAL PRACTICE**

As noted, several factors interfere with the PPR:

### ***Clinicians spend less time with patients***

In the past four decades, despite massive increases in health-care spending and health-care jobs, office time with patients has dropped from 45 min to 12 min<sup>2</sup>. Physicians need to see more patients to accommodate increased demands and to maintain income.

### ***The “art of medicine” is disappearing***

Taking a complete medical history and doing a physical examination have been replaced by brief clinical encounters. The concept of engagement with the patient: being in close proximity, leaning forward, making good eye contact, and using affirmative nods and gestures<sup>3</sup>, has been converted to staring at the computer screen, and thus, patient needs are not being met<sup>4</sup>.

Effective communication skills increase patient satisfaction, and produce positive neurobiological changes<sup>5-7</sup>, and lead patients to provide more specific and meaningful information to help establish clinical priorities. Conversely, the loss of these clinical behaviors diminishes the patient’s role by removing them from participation in their care.

### ***Technology, as a diagnostic resource, is replacing clinical observation and reasoning***

Given the limited time and reduced costs for direct patient visits, there is an increase in medical procedures, including endoscopy, X-ray, and other imaging methods, and unfortunately, diagnosis is relying on these procedures as substitutes. However, particularly for patients with DGBI, symptom-based Rome criteria using the medical interview are needed for diagnosis (DGBI)<sup>8</sup>, and then confidently communicating the diagnosis increases patient acceptance and reduces unneeded endoscopy<sup>9</sup>. We also know that the correlation of patient symptoms with imaging or physiological studies is low: active inflammatory bowel disease (IBD) may have no symptoms, and with IBD-irritable bowel

syndrome (IBS), there may be little disease activity with severe pain<sup>10,11</sup>. Thus, it is essential to use communication skills to learning about the illness experience from the patient and then put any diagnostic or physiological tests into proper perspective<sup>12</sup>.

### ***Increased administrative time to maintain credentialing requirements is consuming the clinician's availability for patient interaction***

Within the USA certification, hospital reappointment credentialing and training for sexual harassment, blood-borne pathogens, tuberculosis infection, fire and environmental safety, HIPPA, and opioid use are increasing. Furthermore, at a global level, the electronic health record, required for billing services occupies the majority of clinic visit time, and this reduces clinician satisfaction due to difficulty learning the process, time-consuming data entry, which interferes with face-to-face patient care<sup>13</sup>. These factors may also contribute to physician burnout<sup>14</sup> and possibly attrition<sup>2</sup>.

### ***Patients with DGBI are seen as second class***

In a traditional health-care environment, more credibility is given to symptoms derived from structurally based diseases, but patients with DGBI have negative imaging and laboratory studies<sup>8</sup>. This may lead clinicians to view patients with DGBI as second class<sup>15</sup>. However, over the past two decades, the field of neurogastroenterology<sup>16</sup> and brain-gut interactions now provides meaningful information on the pathophysiology, diagnosis, and treatment of

these disorders that legitimize them, and this knowledge offers many new options for treatment<sup>8</sup>. Yet many clinicians not familiar with this new knowledge, may feel ineffective in managing these patients. This may lead them to behaviors such as ordering of procedures unlikely to yield meaningful information, avoiding seeing these patients and focusing their time on "organic" or "sicker" patients, or referring them without due cause to mental health providers. Unfortunately, these behaviors are often associated with poor communication and negative attitudes toward patients<sup>17</sup>. What is needed is to provide better training to providers using a biopsychosocial model of illness and disease<sup>18</sup> so clinicians can use their new scientific knowledge along with effective communication skills to gain competency and engage with and actuate patients in their care.

### ***Impact on the patient***

These factors affect how patients perceive their providers. In one internet survey of IBS patients, 40% were not at all or only a little bit satisfied with the care provided by their physicians<sup>19</sup>. After a clinical visit at a medical institution, patients were asked: "please describe your provider in today's visit in 2 words"<sup>20</sup>. Word clouds represented the frequency of patient responses. The positive attributions were few: knowledgeable, professional, and caring. However, the negative ones were higher in number and focused on the doctors being rushed, unconcerned, indifferent, uncaring, arrogant, and even rude.

One crucial factor that affects patients with DGBI is that of feeling stigmatized. Clinicians do not give high priority to caring for patients

**TABLE 1.** Verbal and non-verbal behaviors affecting communication<sup>24</sup>

Behavior	Facilitates	Inhibits
Nonverbal Clinical environment Eye contact Listening  Body posture Head nodding Body proximity Facial expression Voice Touching  Synchrony (arms, legs)	Private, comfortable Frequent Active listening – questions relate to what the patient says Direct, open, relaxed Well-timed Close enough to touch Shows interest and understanding Gentle tone Helpful if well-timed and used to communicate empathy Concordant	Noisy, physical barriers Infrequent or constant Distracted or preoccupied (e.g., typing)  Body turned, arms folded Infrequent, excessive Too close or too distant Preoccupation, boredom, disapproval Harsh, rushed Insincere if inappropriate or not properly timed  Discordant
Verbal Question forms      Question/interview style	Open-ended to generate hypotheses Closed-ended to test hypotheses Use of patient's words Facilitates patient discussion by “echoing” or affirmative gestures Uses summarizing statements  Nonjudgmental Follows the lead of patient's prior comments (patient-centered) Use of a narrative thread Appropriate use of silence Appropriate reassurance and encouragement Communicates empathy	Rigid or stereotyped style Multiple choices or leading questions (“you didn't...did you?”) Use of unfamiliar words or jargon Interruptions, undue control of conversation Not done  Judgemental Follows own preset agenda or style Unorganized questioning Interruptions or too much silence Premature or unwarranted reassurance or encouragement Not provided or not sincere
Recommendations	Elicits feedback and negotiates	No feedback, directly states views
Asks/provides medical information	As appropriate to the clinical issues	Too many biomedical questions and too detailed information
Asks/provides psycho-social information	Elicits in a sensitive and non-threatening manner	Ignores psychosocial data or asks intrusive or probing questions
Humor	When appropriate and facilitative	None or inappropriate humor

not having structural disorders. This has negative consequences for these patients. Some patients may reject the diagnosis and seek other clinicians to get a different diagnosis, which only perpetuates the problem of unneeded health care-seeking. However, if they accept it, the clinician's behavior leads them to believe the disorder is not real or is psychiatric (i.e., “crazy”), and this can lead to feelings of guilt and self-blame. The PPR is impaired as the patients feel disengaged from their care and less comfortable expressing their thoughts and feelings that are relevant for diagnosis and management<sup>21,22</sup>. Often, as

shown in one focus group, patients with IBS did not inform their family members and friends about their diagnosis, fearing they would be misunderstood or not believed<sup>23</sup>. Training in the diagnosis and management of DGBI and the application of communication skills can reverse this problem.

## VALUE OF COMMUNICATION SKILLS TO IMPROVE THE PPR

Table 1 demonstrates several verbal and non-verbal behaviors that affect communication. The

bases for implementing these and other communication skills lies with several established benefits.

### ***Improves diagnostic accuracy and clinical decisions***

As discussed later, methods such as active listening, addressing the patient's agenda, providing empathy, and validating patient beliefs and concerns<sup>24</sup>, allow the patient to provide the clinical and psychosocial information needed for diagnosis and management.

### ***Establishes trust***

Methods of engagement with the patient create a trusting environment for patients to share their deepest thoughts and feelings, which may be contributing to the illness. This information also helps the clinician understand the full impact of the patient's illness on them and their world view. All of this facilitates shared decision-making and lead to optimal treatment.

### ***Creates a collaboration of care***

With acute illness such as a bowel obstruction or gastrointestinal bleed, responsibility for the care resides primarily with the clinician. However, with chronic illness such as with DGBI, responsibility for the care is shared. This approach called patient-centered care (see below), empowers the patient and offloads any undue burden of responsibility on the part of the clinician. Shared

decision-making enhances the sense of collaboration<sup>25</sup>, identifies other treatment options that the patient is motivated to engage in, increases mutual "liking" between patient and provider<sup>26</sup> and may reduce malpractice suits<sup>27</sup>.

### ***Improves time efficiency***

A skilled patient-centered interview saves time. Good interviewers talk less and listen more<sup>24</sup>. With active listening, the questions are constructed based on what the patient has said, which facilitates further disclosure and an understanding of the patient's biopsychosocial world. An effective communication style compared to a more traditional one is demonstrated in supplementary video 1: <http://bit.ly/2H7MHb3>.

### ***Benefits the patient, provider, and clinical outcome***

The patient benefits through engagement and trust with the clinician, getting their needs addressed, receiving clear information, and a mutual set of goals and treatment. By learning effective communication skills, the clinician gains satisfaction and meaningfulness<sup>28</sup> in the clinical practice, and with reduced emotional exhaustion, and burnout<sup>29,30</sup>. Finally, regarding the outcome, an effective patient-provider interaction reduces the patient's symptom severity and emotional distress and improves the patient's quality of life and coping and with reduced use of health-care services<sup>24,31,32</sup>.

## **A STRATEGY FOR APPLYING EFFECTIVE COMMUNICATION SKILLS**

### ***Establishing patient-centered care***

In 2001 the Institute of Medicine published “Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century”<sup>33</sup> and stated that the inefficiencies of American health care were due to poor communication. The report stated that clinicians needed to provide patient-centered care defined as being respectful and responsive to patient needs and preferences with the patient helping to guide clinical decisions. This term may be misunderstood by some who believe that a clinician might give up control to the patient. For that reason, some have considered changing the term to “relationship-centered care” which clarifies the collaborative nature of the clinical interaction.

There are several components to establishing patient-centered care: (1) respect for the patient’s knowledge and perspective, even if it differs from the clinician’s, (2) providing physical comfort and emotional support, (3) offering education and reassurance, (4) being accessible and collaborative, and (5) making decisions based on patient preferences. To accomplish these goals, the clinician uses effective communication strategies to understand the full nature of the patient’s symptoms, and their illness experience in addition to their needs, perceptions, concerns, and impact the illness is having on their life.

### ***Twelve tips to maximize the PPR***

The following guidelines developed by one of the authors (DAD) provide a basis for providing

patient-centered care and enhancing the PPR<sup>24</sup>. This information is seen in supplementary video 2, which also addresses the concept of stigmatization of patients with DGBI: <http://bit.ly/2HbpVDy>.

### ***LISTEN ACTIVELY***

Don’t jump in with questions unless you’ve made efforts to understand the patient’s perspective (“don’t just do something, stand there”). The clinician obtains data through an active process of listening, observing, and facilitating. Active listening constructs questions that are based on what the patient says, rather than from a personal agenda.

### ***UNDERSTAND THE PATIENT’S AGENDA***

The issues patients seek to address are often not stated because they have not been given the opportunity or have not been aware of them until the clinical visit. Common concerns relate to the impact of the illness on their life, the possibility of cancer, fear for future consequences, and many more. A discussion of these issues improves patient satisfaction. Here are four critical questions to ask on the first visit:

- a. *What brought you here today?* There can be many reasons for a clinical appointment: symptoms may be worse, there may be major psychological stress occurring, the patient is worried about cancer, etc. Knowing the reason can help gauge the conduct of the visit.
- b. *What do you think you have?* Patients may have certain beliefs or concepts (called “schema”), which are personal, familial, or

cultural. Understanding them can be used in shaping the treatment plan.

- c. *What worries or concerns do you have?* Patients often worry about cancer or other serious conditions but may not volunteer that concern. By offering the opportunity to express their concerns, the patient is more to disclose that information and be receptive to hear the clinician's perspective on the matter.
- d. *What do you feel I can do to help?* Patients may hold unrealistic expectations, for example, to be cured, when the disease is chronic.

## **EMPATHIZE**

Empathy can be taught<sup>34</sup>; it improves patient satisfaction and leads to adherence to treatment<sup>35</sup>. An empathic statement would be: *"I can see how difficult it is been to manage with your pain."* Empathy incorporates four components:<sup>36</sup>

- a. Perspective-taking: seeing the world as the patient sees it
- b. Being non-judgemental
- c. Recognizing the emotions and understanding the patient's feelings
- d. Communicating that understanding to the patient.

## **VALIDATE THOUGHTS AND FEELINGS**

Validating the patient's thoughts and feelings provides acknowledgment and legitimization. Validation is of special importance for patients with DGBIs who are frequently told their symptoms are psychologically based. The clinician provides an air of openness and acceptance of the patient's perspective<sup>37</sup>, even though they may not agree. A validating statement for a patient who feels stigmatized

by others who say their problem is due to stress would be: *"I can see you are upset when people say this is due to stress and you know it's real."* This statement also opens the door to further dialog about the role of stress in illness.

## **SET REALISTIC GOALS**

Some patients with chronic illness may seek a rapid diagnosis, perhaps of structural disease, and a cure. However, the clinician may see the need to focus on ongoing management with realistic expectations for the outcome. Reconciliation of these differences needs to occur. Here, you can say: *"I can understand how much you want these symptoms to go away, but they are longstanding, and as such we need to reset our expectations. If we could seek to reduce your symptoms by 30 % over the next several months would that help?"*

## **EDUCATE**

Education is a four-step iterative process:

- a. Elicit the patient's understanding
- b. Addressing misunderstandings
- c. Providing information consistent with the patient's understanding
- d. Checking the patient's understanding of what was discussed.

This process is also facilitated by providing diagrams, modeling, and other manipulatives when needed. Then, the clinician checks on the patient's understanding and provides additional follow-up materials that the patient can take home to learn more on their own time. By giving the patient a clear understanding of the condition and the

agreed-upon treatment, the patient achieves a better sense of control over their symptoms and participates in the care as a team with the physician to manage their health long term.

### **REASSURE**

Reassurance requires you to:

- a. Identify the patient's worries and concerns
- b. Acknowledge and validate them
- c. Respond to these specific concerns
- d. Avoid false reassurances (e.g., "don't worry about it") that can sound dismissive as if their feelings are not valid.

### **NEGOTIATE**

Patient-centered care requires mutual agreement on diagnostic and treatment options. The clinician, after eliciting the patient's personal experience, understanding, and interests in various treatments, then provides choices (rather than directives) that are consistent with the patient's beliefs.

### **HELP THE PATIENT TAKE RESPONSIBILITY**

Patients with chronic illness do best when they take responsibility for their care, and clinicians must encourage this. Hence, rather than asking the patient: "how is your pain doing?" you might say: "how are you managing with your pain?" The second question encourages the patient rather than the clinician to take an active role in management. This approach also offsets clinicians from feeling pressured to take more responsibility than needed. With treatment, it is wise to

offer several treatment approaches with a discussion of their risks and benefits so that the patient can make a proper choice.

### **BE THERE**

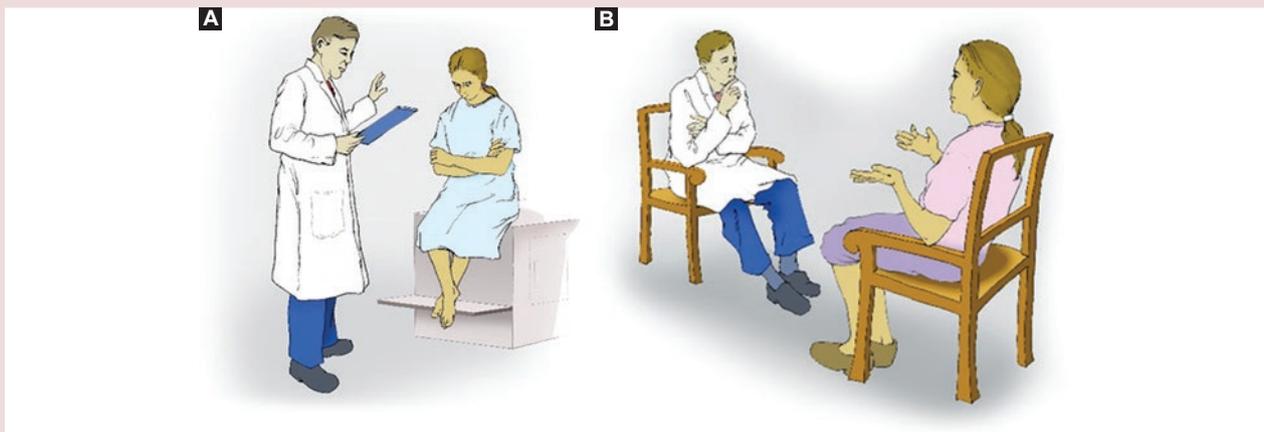
This means providing support and a listening ear. Sometimes patients disclose personally significant and sensitive issues that have no simple solutions. They are not seeking a simple solution as much as to know they are being heard, understood, and supported.

### **ESTABLISH BOUNDARIES**

For some patients, it's important to establish and maintain "boundaries" related to frequent phone calls, unexpected visits, a tendency toward lengthy visits, or unrealistic expectations for care. The clinician needs to present expectations in a way that is not perceived as rejecting or belittling to the patient yet is also consistent with personal needs. For example, if a patient calls by phone off hours, the clinician can gently remind the patient that it would be better to have the discussion in the office or at the next visit. Here, it is important not to try to address the issue on the phone as that might encourage further phone calls.

### **BE AWARE OF TIME CONSTRAINTS**

As discussed, clinicians have less and less time to spend with patients. Learning high-quality communication skills can save time by establishing a satisfying relationship with only a few simple techniques, as noted



**Figure 1. A:** There is a lack of engagement. The doctor is avoiding eye contact while looking at the medical record and is turned away from the patient. He waves his hand in a way that dismisses the patient. The patient, in turn, is looking down with slumped shoulders and with crossed arms and legs displaying passivity and non-acceptance. **B:** The doctor is facing the patient and making good eye contact. The finger on his chin indicates both receptive thinking and active engagement. To the patient this communicates interest and acceptance by the doctor of what she is saying. This reinforces the patient to say more as she looks back at him with an open posture and active gesturing.

below. Some patients may desire more time or make frequent phone calls. Here, setting limits on time can be accomplished by scheduling brief but regular appointments of a fixed duration, rather than attempting to extend the time of a visit.

### **THE VALUE OF NON-VERBAL BEHAVIOR AND BODY LANGUAGE IN COMMUNICATION<sup>3,21,38</sup>**

With effective communication, one aphorism is: "it is not what you do but how you do it that makes the difference." Nonverbal communication is the underpinning that establishes a sense of connection. Gestures, proxemics, and nonverbal signals are the most primitive and basic form of communication that pre-exists language, and they legitimize the credibility and integrity of what is said. Effective nonverbal communication is associated with greater patient satisfaction, adherence to treatment and a larger

patient caseload due to patient satisfaction<sup>39</sup>. Consider the two figures (Fig. 1A and B) of a patient-provider interaction<sup>38</sup>. What can you learn about this relationship even without hearing the words?

In figure 1A, the doctor:

- Avoids eye contact while looking at the medical record
- Is turned away from the patient
- Waves his hand in a dismissive manner.

The patient:

- Looks down with slumped shoulders
- Crosses arms and legs showing passivity and nonacceptance.

Whereas in figure 1B, the doctor:

- Faces the patient making good eye contact
- The finger on the chin indicates receptive thinking and active engagement.

The patient:

- Perceives greater interest and acceptance.
- She is encouraged to say more
- Now displays an open posture and active gesturing.

## **The patient's role in the process**

A positive PPR that achieves positive outcomes does not rest on the provider alone. There are some key elements the patient also needs to consider. What follows are guidelines for patients in establishing the PPR.

As a patient, you should have realistic expectations of your physician; there is no “magic wand” when diagnosing and treating chronic illness. It may take time for your doctor to make a confident diagnosis and not to overlook other influencing factors in the illness, including comorbidities that might contribute to the symptoms and their severity.

Here are several guidelines for you to consider when working with your physician and in your self-management:

- *Be clear and concise with the physician:* Indicate why you are seeking the physician's help and your expectations.
- *Be honest with the physician:* Indicate your perspective of the illness, the nature of your symptoms, including the onset, frequency, and duration, and the impact of the illness on your quality of life. Sometimes it helps to prepare your comments and bring notes.
- *Communicate your worries and concerns:* Remember that there are no “dumb” questions. Your thoughts, emotions, and fears are all valid and must be addressed appropriately for you to feel confident to participate in the diagnosis and treatment.
- *Bring along a family member or friend if needed:* This person can provide support, offer additional questions, and help you later remember relevant things.
- *Be assertive and confident:* Make your thoughts manifest in your responses to the physician's questions, and when discussing diagnosis and treatment. Be sure to ask for clarification or further explanation when needed.
- *Understand you are a partner with the physician in your care:* Patient-centered care is a participatory process. You work with your physician on diagnostic approaches and goal setting and the final decision is yours.
- *Work with the physician to customize a treatment plan that works best for you:* Many times; this might involve a multi-tiered approach such as diet, exercise, medication, and even the addition of psychological therapy such as mindfulness, cognitive behavioral therapy, or gut-directed hypnotherapy to manage chronic pain. Thus, it is essential, to be honest about how you understand and feel about the treatment options: you need to know how each work, the side effects, effectiveness, and the duration of treatment required before proceeding. You need to feel good about following the diagnosis or management plan.
- *Once you have a diagnosis and treatment plan, your role is to set realistic management goals to move toward recovery:* Sometimes, this means resetting priorities. For example, if symptoms kept you from going to your child's sporting events, make that a new goal to be achieved by following recommendations for rest, diet, medication, and stress reduction, and then attending the sporting events becomes a reality. This might mean saying no to other things to prioritize your health and family. Remember, there is power, and control is saying “no” to what is no longer important for the sake of your health!

**TABLE 2.** What doctors and patients should know<sup>38</sup>

Doctors should know and be able to show	Patients should know
That you care about your patients and are not judgemental	Their role in the care and their health status are worth fighting for, no matter what
You respect your patients enough that they can share personal details that will assist you in their care	They can demand to be treated with dignity and respect
That you are receptive to their thoughts and feelings	They have a right to share personal thoughts and feelings about their illness and care
Patients need to understand the diagnosis and treatment plan to participate and feel like they have a say in the process	They have a right to ask questions and receive visual aids to understand the diagnosis and treatment
That patients are not impressed with ego and prestige. They want you to be humane and to care about the impact of the illness on their life	They have a right to be heard
That it is okay to say "I don't know" as long as you continue to work with them or guide them to someone who will	They have the right to engage with you, the provider, as a partner
That you will not abandon them in the care	They have the right to refuse treatment or seek another opinion if their needs are not being met

- *Be aware of your rights in the health-care process:* Some patients may struggle with inadequate care often by physicians who are dismissive or stigmatizing. These patients are at risk of ending up suffering in silence or going from physician to physician, trying to find answers, and getting increasingly frustrated by each encounter. All patients have the right to be treated with respect, and to ask questions and voice objections or opinions. You also have the right to disagree and to say no to treatment without feelings of guilt or shame and, if necessary, to seek a second opinion.
- *Expect a commitment from your physician:* If a physician does not communicate that they are committed to long-term care in a partnership with the patient, it is safe to say that the quality of the relationship will be weak, one-sided, and not beneficial for either person. You then have the right to go elsewhere.
- *Find your new life:* Once you have established a positive relationship with your

provider and are managing your health as a team, try to bring new focus to other key areas of your life that bring meaning and joy. Refocus away from what you cannot do towards what you can do bring back control and normalcy.

- *You are not alone:* Always remember there are other patients who share your illness and burden. Your physician is a partner in managing with you the burden of illness. There are also family and friends who want to help. All of this means there is hope to move forward and manage your health long term.

### **What providers and patients should know<sup>21,38</sup>**

As discussed, the PPR is a partnership where both providers and patients share responsibility. To accomplish this, it is important to become familiar with each other's needs and expectations. Table 2 provides some guidelines<sup>38</sup>.

## CONCLUSION

In this article, we provide information to demonstrate that effective PPR is essential to optimizing patient care. Nevertheless, extraneous factors such as reduced time for patient visits, increased administrative tasks, and greater reliance on technology over the face to face interaction continue to challenge this relationship. To address these constraints, we offer easy to apply and effective communication strategies that increase patient satisfaction in a time-efficient manner. Further a meaningful PPR also requires active participation from the patient. In this context, we also offer recommendations for patients to use in their clinical visits and self-management.

## SUPPLEMENTARY DATA

Supplementary data are available at NeuroGastroLATAM Reviews online: ([www.neurogastrolatamreviews.com/index.php](http://www.neurogastrolatamreviews.com/index.php)). These data are provided by the corresponding author and published online for the benefit of the reader. The contents of supplementary data are the sole responsibility of the authors.

Supplementary Video 1. Ineffective and effective interview: <http://bit.ly/2H7MHb3>.

Supplementary Video 2. TED-like talk on stigmatization: <http://bit.ly/2HbpVDy>.

## REFERENCES

- Drossman DA. Medicine has become a business, but what is the cost? *Gastroenterology*. 2004;126:952-3.
- Topol EJ. *Deep Medicine: how Artificial Intelligence can Make Healthcare Human Again*. 1<sup>st</sup> ed. New York: Basic Books; 2019.
- Hall JA, Harrigan JA, Rosenthal R. Nonverbal behavior in clinician-patient interaction. *Appl Prevent Psychol*. 1995;4:21-37.
- Jackson JL, Chamberlin J, Kroenke K. Predictors of patient satisfaction. *Soc Sci Med*. 2001;52:609-20.
- Vergheze A, Brady E, Kapur CC, Horwitz RI. The bedside evaluation: ritual and reason. *Ann Intern Med*. 2011;155:550-3.
- Costanzo C, Vergheze A. The physical examination as ritual: social sciences and embodiment in the context of the physical examination. *Med Clin North Am*. 2018;102:425-31.
- DiMatteo MR, Taranta A, Friedman HS, Prince LM. Predicting patient satisfaction from physicians' nonverbal communication skills. *Med Care*. 1980;18:376-87.
- Drossman DA. Functional gastrointestinal disorders: history, pathophysiology, clinical features and rome IV. *Gastroenterology*. 2016;150:1262-79.
- Linedale EC, Chur-Hansen A, Mikocka-Walus A, Gibson PR, Andrews JM. Uncertain diagnostic language affects further studies, endoscopies, and repeat consultations for patients with functional gastrointestinal disorders. *Clin Gastroenterol Hepatol*. 2016;14:1735-410.
- Long MD, Drossman DA. Inflammatory bowel disease, irritable bowel syndrome, or what? A challenge to the functional-organic dichotomy. *Am J Gastroenterol*. 2010;105:1796-8.
- Drossman DA, Ringel Y. Psychosocial factors in ulcerative colitis and Crohn's disease. In: Sartor BR, Sandborn WJ, editors. *Kirsner's Inflammatory Bowel Disease*. 6<sup>th</sup> ed. London: W.B. Saunders; 2004. p. 340-56.
- Oudenhove LV, Levy RL, Crowell MD, Drossman DA, Halpert AD, Keefer L, et al. Biopsychosocial aspects of functional gastrointestinal disorders: how central and environmental processes contribute to the development and expression of functional gastrointestinal disorders. *Gastroenterology*. 2016;150:1355-67.
- Friedberg MW, Chen PG, Van Busum KR, Aunon F, Pham C, Caloyeras J, et al. Factors affecting physician professional satisfaction and their implications for patient care, health systems, and health policy. *Rand Health Q*. 2014;3:1.
- Shanafelt TD, Dyrbye LN, Sinsky C, Hasan O, Satele D, Sloan J, et al. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction. *Mayo Clin Proc*. 2016;91:836-48.
- Drossman DA. Functional GI disorders: what's in a name? *Gastroenterology*. 2005;128:1771-2.
- Boeckxstaens G, Camilleri M, Sifrim D, Houghton LA, Elsenbruch S, Lindberg G, et al. Fundamentals of neurogastroenterology: physiology/motility sensation. *Gastroenterology*. 2016;150:1292-304.
- Dalton CB, Drossman DA, Hathaway JM, Bangdiwala SI. Perceptions of physicians and patients with organic and functional gastrointestinal diagnoses. *Clin Gastroenterol. Hepatol* 2004;2:121-6.
- Engel GL. Sounding board. The biopsychosocial model and medical education. Who are to be the teachers? *N Engl J Med*. 1982;306:802-5.
- Drossman DA, Morris CB, Schneck S, Hu YJ, Norton NJ, Norton WF, et al. International survey of patients with IBS: symptom features and their severity, health status, treatments, and risk taking to achieve clinical benefit. *J Clin Gastroenterol*. 2009;43:541-50.
- Singletary B, Patel N, Heslin M. Patient perceptions about their physician in 2 words: the good, the bad, and the ugly. *JAMA Surg*. 2017;152:1169-70.
- Drossman DA. From pretending to truly being ok: a journey from illness to health with postinfection irritable bowel syndrome: the provider's perspective. *Gastroenterology*. 2018;155:1664-5.
- Rocque R, Leanza Y. A systematic review of patients' experiences in communicating with primary care physicians: intercultural encounters and a balance between vulnerability and integrity. *PLoS One*. 2015;10:e0139577.
- Drossman DA, Chang L, Schneck S, Blackman C, Norton WF, Norton NJ, et al. A focus group assessment of patient perspectives on irritable bowel syndrome and illness severity. *Dig Dis Sci*. 2009;54:1532-41.
- Drossman DA 2012 david sun lecture: helping your patient by helping yourself how to improve the patient-physician relationship by optimizing communication skills. *Am J Gastroenterol*. 2013;108:521-8.

25. Matthews DA, Suchman AL, Branch WT Jr. Making “connexions”: enhancing the therapeutic potential of patient-clinician relationships. *Ann Intern Med.* 1993;118:973-7.
26. Hall JA, Horgan TG, Stein TS, Roter DL. Liking in the physician patient relationship. *Patient Educ Couns.* 2002;48:69-77.
27. Beckman HB, Markakis KM, Suchman AL, Frankel RM. The doctor-patient relationship and malpractice. Lessons from plaintiff depositions. *Arch Intern Med.* 1994;154:1365-70.
28. Horowitz CR, Suchman AL, Branch WT Jr, Frankel RM. What do doctors find meaningful about their work? *Ann Intern Med.* 2003;138:772-5.
29. Penberthy JK, Chhabra D, Ducar DM, Avitabile N, Lynch M, Khanna S, et al. Impact of coping and communication skills program on physician burnout, quality of life, and emotional flooding. *Saf Health Work.* 2018;9:381-7.
30. Boissy A, Windover AK, Bokar D, Karafa M, Neuendorf K, Frankel RM, et al. Communication skills training for physicians improves patient satisfaction. *J Gen Intern Med.* 2016;31:755-61.
31. Roter DL, Hall JA, Kern DE, Barker LR, Cole KA, Roca RP, et al. Improving physicians’ interviewing skills and reducing patients’ emotional distress. A randomized clinical trial. *Arch Intern Med.* 1995;155:1877-84.
32. Weiland A, Van de Kraats RE, Blankenstein AH, Van Saase JL, Van der Molen HT, Bramer WM, et al. Encounters between medical specialists and patients with medically unexplained physical symptoms; influences of communication on patient outcomes and use of health care: a literature overview. *Perspect Med Educ.* 2012;1:192-206.
33. *Medicine Io. Crossing the Quality Chasm: a New Health System for the 21<sup>st</sup> Century.* 1<sup>st</sup> ed., Vol. 1. Washington, DC: National Academy of Sciences; 2001.
34. Riess H, Kelley JM, Bailey RW, Dunn EJ, Phillips M. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *J Gen Intern Med.* 2012;27:1280-6.
35. Spiro H. What is empathy and can it be taught? *Ann Intern Med.* 1992;116:843-6.
36. Wiseman T. A concept analysis of empathy. *J Adv Nurs.* 1996;23:1162-7.
37. Roter DL, Hall JA. *Doctors Talking with Patients/Patients Talking with Doctors: improving Communication in Medical Visits.* 2<sup>nd</sup> ed. Westport, CT: Praeger Publishing; 2006.
38. Ruddy J. From pretending to truly being ok: a journey from illness to health with postinfection irritable bowel syndrome: the patient’s perspective. *Gastroenterology.* 2018;155:1666-9.
39. DiMatteo MR, Hays RD, Prince LM. Relationship of physicians’ nonverbal communication skill to patient satisfaction, appointment noncompliance, and physician workload. *Health Psychol.* 1986;5:581-94.