Talk to Your Patient, Doc!

Communication is the key to unlocking all doors.

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Whether patients take good care of themselves is closely tied to how they relate to their doctors and how their doctors relate to them.[1,2] That relationship greatly depends upon the language and body language of both the doctor and the patient. With that in mind, it is instructive to consider the words and phrases that we physicians often use when talking to patients.

CHIEF COMPLAINT

At the top of our patient data form is frequently the phrase *chief complaint*. Patients come to us with concerns and worries, which we call *complaints*. People complain because their taxes are too high or because their spouse is insufficiently loving. Having eyes that hurt or do not see well is not a complaint; it is a concern. We need to recognize what we are actually saying and how we are coming across to our patients. If we do, we will start discussing chief concerns.

COMPLIANCE

When patients do not do what we ask, we label them *noncompliant*. Compliance means going along with something that somebody else has told you to do. The very word indicates a relationship in which the doctor thinks he or she is right, has the privilege to dictate what he or she wants, and may require patients to do what he or she believes is best. Compliance immediately sets up a hierarchy in which the doctor is powerful.

The first tenant of ethical behavior for a physician dealing with patients is to respect their autonomy, that is, to help patients to be in control of their lives. If we want to communicate well with our patients, then we should do away with the word *compliant* and all that it implies.

ARE YOU USING YOUR EYE DROPS AS I TOLD YOU TO?

How is a patient to respond other than yes? Questions such as this one almost never produce meaningful information, and they certainly do not enhance communication. We must phrase our inquiries in a nonjudgmental way while recognizing that some responses suggest that a patient needs to change his or her way of doing things.[3-5] For example, we may comment, "I would like to know how you use your medications." The patient responds, "I have trouble with them, and I frequently forget to use the evening drop."

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We should not criticize patients for this response, but we must make it clear that either (1) they need to figure out how to run their lives so that they do not forget their evening drop or (2) a different mode of treatment, such as surgery, will be a better choice. We cannot allow patients to accept their own lapses in therapy, but we must convey that information in a way that encourages hope rather than instills fear.

YOUR IOP IS 15

This statement implies that the IOP is, was, and will continue to be 15 mm Hg. Every statement we make educates patients. If we really want them to understand that IOP is only one of the many factors influencing management and that it is a measure that is slippery at best, then we have to say something like, "Your IOP is currently around 15." Such a statement indicates to the patient that we do not really know what his or her pressure is, even at this moment, and that we have very little idea what it was the day before or will be the next day. We ourselves have to realize that we have only a rough idea of what a patient's IOP is when we measure it.

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YOU ARE WORSE

We routinely confuse aspects of our patients with the patients themselves. When the visual fields appear to be stable, we doctors routinely say, "You are stable." When the visual field has gotten worse, we commonly say, "You are worse." It is the fields that have gotten worse; the patient may not have gotten worse at all. To confuse the person with his or her fields is to demean that individual.

NO

Patients often ask, "Doctor, do I have glaucoma?" Because most of them do not have actual manifestations of the disease, the usual answer to that question would seem to be no. It is impossible to say, however, that a patient does not have the early stages of glaucoma. A better response to the question would be, "At the present time, I don't see any manifestations of glaucoma. That's good news, but you have a family history of glaucoma and therefore are at risk for developing it. If we start treatment in the early stages, you will probably do well. So, please make sure you return for your appointment in a year and ask me the same question then, and I hope I will give you the same answer, specifically, I don't see any manifestations of glaucoma."[6]

Glaucoma has been defined in so many ways over so many years that the word is almost meaningless. It may be a condition that will inevitably lead to blindness, or it may be high IOP or optic neuropathy. Patients really want to know what will happen to them. Thus, our answer needs to address that issue.

CONCLUSION

We must speak to specific people, not generic types. One of the authors was seeing an elderly lady as a patient and treating her respectfully. Unfortunately, she sensed that she was being looked at as if she were elderly and feeble but not as a particular person. She said, with vehemence, "Talk to me, not to the old lady!"

We must always speak to a specific person if we wish the communication to be meaningful. Even thinking about the individual with whom we are dealing as "patient" puts boundaries on that person that will affect how we deal with him or her. A patient is somebody to whom we relate in a professional capacity; we are in charge, and he or she is seeking our help and advice. A person is a unique individual who, at the moment, is seeking our help and advice but who is far more than just a patient.

The French philosopher and writer Voltaire said, "Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing." It is time we changed. ■

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