Doctor-patient communication

When you talk to a patient, you will tend to have a preferred style, and when you are a patient you will have a preferred way of being communicated with; both of these are likely to be related to your psychological type. The same is true when a patient talks to you, and of course, their preferences may be entirely different to yours. The result is that your preferred communication style will work for some patients, but not for all.

When communication is ineffective, patients are not only in danger of being unnecessarily distressed, but they may also doubt your competence, and we know that most complaints against doctors focus on communication rather than clinical shortcomings. Personality type will affect communication style in any situation, be it with colleagues, junior staff, students, friends, family, or patients; but the greater the inequality in a relationship, the less likely it is that the “weaker” of the two will demand the kind of information and attitude they are needing. Understanding how type can inform and improve communication is therefore particularly important and helpful in a clinical setting.

How can you know what communication style to use with a particular patient?

The previous articles have underlined the fact that we all use all the preferences, the difference being only in the order and ease of that use. It has also been described how our behaviour can alter when we’re stressed. For these reasons it is not only unnecessary to know a patient’s preferences in order to conduct a consultation, but it could be misleading. For example, if you knew a patient had preferences for Extraversion, Intuition, and Feeling you might not pick up on the fact that today—possibly because he or she is coming to discuss potentially worrying test results—that patient is contained (Introversion), relatively impersonal (Thinking), and focused on hearing the detailed results of the test (Sensing).

What is important is to be able to tune into a patient’s current communication style, described as “type mode.” Figure 1 shows some research based descriptions of what you might see and hear from individuals with contrasting type preferences.

Spotting type cues

All good doctors will be alert to their patients’ needs and will be used to adapting their style and the content of what they are saying to what the patient is asking for, or seems to be wanting. Nevertheless, being aware of type gives a useful framework for recognising communication preferences, as well as some detailed guidance, and if you decide to pay attention to type when dealing with patients, you will become more and more adept at spotting what they are needing.

<table>
<thead>
<tr>
<th>Extraversion (E)</th>
<th>Introversion (I)</th>
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<tbody>
<tr>
<td>• Rapid speech</td>
<td>• Pauses in answering or giving information</td>
</tr>
<tr>
<td>• Seems to think aloud</td>
<td>• Appears to be thinking things through</td>
</tr>
<tr>
<td>• Interrupts</td>
<td>• Quieter voice volume</td>
</tr>
<tr>
<td>• Louder volume to voice</td>
<td>• Shorter sentences that don’t run on</td>
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<tr>
<th>Sensing (S)</th>
<th>Intuition (N)</th>
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<tr>
<td>• Asks for step by step information or instructions</td>
<td>• Asks for the purpose of the action</td>
</tr>
<tr>
<td>• Asks about the present situation</td>
<td>• Asks “why” questions</td>
</tr>
<tr>
<td>• Asks “what” and “how” questions</td>
<td>• Talks in general terms and possibilities</td>
</tr>
<tr>
<td>• Uses precise descriptions</td>
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<table>
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<tr>
<th>Thinking (T)</th>
<th>Feeling (F)</th>
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<tr>
<td>• Weights up the objective evidence</td>
<td>• Strives for harmony in the interaction</td>
</tr>
<tr>
<td>• Not impressed by what others decide</td>
<td>• May talk about “value”</td>
</tr>
<tr>
<td>• Conversations follow a pattern of checking logic, “If this, then that.”</td>
<td>• Asks how others have acted or resolved a similar situation</td>
</tr>
<tr>
<td></td>
<td>• Matters to them whether others have been taken into account</td>
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<tr>
<th>Judging (J)</th>
<th>Perceiving (P)</th>
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<tr>
<td>• Impatient with overly long descriptions or procedures</td>
<td>• Seeks to want “space” to make a decision</td>
</tr>
<tr>
<td>• The tone is “Hurry up… I want to make this decision.”</td>
<td>• The tone is, “Let’s explore, what are some more factors to consider?”</td>
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<tr>
<td>• May make decisions prematurely</td>
<td>• May decide at the last moment</td>
</tr>
<tr>
<td>• Enjoys getting things done</td>
<td>• Enjoys processing</td>
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</table>

When you see a patient next, you might like to try taking a few moments after the consultation to ask yourself the following questions.

What did you notice about the way in which this patient was talking?

Remember that people preferring extraversion tend to talk relatively quickly, at a higher volume, and to think aloud, while those preferring introversion tend to be more sparing in their speech, and to pause before answering questions or making decisions.

What kinds of questions was he or she asking?

People preferring sensing are more likely to ask for details about their results and diagnosis, and want a step by step explanation. People preferring intuition are more likely to ask “Why?” questions about their condition and want to understand the broad implications for the future.

Example of how minor adaptations in style can have a major benefit

A doctor working in accident and emergency found that when he asked patients a lot of detailed questions, many of them glared over after a while, and he wondered why. He had a preference for specific (Sensing) information, and in a typical case where the patient had possibly fractured a wrist he would ask:

1. (1) How did you fail?
2. (2) Where did you land?
3. (3) Where does it hurt?
4. (4) Can you move your wrist this way—or that way?

He discovered from working with the Myers-Briggs Type Indicator that it sometimes helped to outline the bigger picture (Intuition) first: “I think you may have broken your wrist [big picture], and so I need to ask you some questions.”

He added that he had always thought everyone needed the level of detail that he did. The adjustment of his style was minor, but he found the impact to be huge.
Doctors who prefer When talking to patients who prefer Could try to
Extraversion Introversion Use a slower pace and give time for the patient to reflect
Introversion Extraversion Show more energy and give space for the patient to talk
Intuition Sensing Give detailed information in a stepwise, fashion, and practical examples
Sensing Intuition Give the big picture first (see box)
Feeling Thinking Keep to objective facts and logical information
Thinking Feeling Take an interest in the patient as an individual, showing concern
Judging Perceiving Provide space for the patient to explore and clarify the options
Perceiving Judging Agree an agenda for action including, where possible, dates by which each item will be dealt with

Fig 2 Tips for flexing your style during consultations

What criteria was he or she using for deciding on treatment? If you gave the patient a choice of courses of action, what kinds of things did they seem to be basing their decision on? Did it seem to be based on logic, cause and effect, and objective evidence (T)? Or was it the implications of treatment for themselves and those close to them (F)? What clues did they give in their questions?

What did you sense he or she wanted from you as a human being? People with a preference for thinking tend to prefer an objective, impersonal approach and may be irritated by what they may see as a touchy-feely approach. Those preferring feeling will tend to want some kind of personal connection with their doctor, and value attempts to understand how they are feeling. Was their style detached, scientifically inquiring, and their conversation restricted to objective facts related to the matter in hand? Or did the patient smile? Volunteer personal information? Did they express emotion or tell you how they were feeling?

How quickly did they want to make their decision? People who prefer judging are more comfortable when everything is decided, and will tend to decide quickly, sometimes without all the necessary information. Those who prefer perceiving are likely to ask for more information, be reluctant to decide, and may change their minds more than once. Judging types tend to be more interested in the outcome, and perceiving types in the process.

How did I respond to their preferences? Consider your own style, and how it fitted with the patient’s. If the styles were at variance, in what way was that obvious? Did you adapt, and if so, what did you do specifically? And how did the patient respond when you adapted your style to theirs?

How do you adapt your style for different types? In a cohort study of medical students, Clack found that over 50% of those entering hospital medicine preferred Intuition, compared with only 25% of the general public. Therefore, if you prefer Intuition, there is a 75% chance that the patient in front of you will have a different preference for taking in information to your own. About two thirds of the cohort preferred Thinking, whereas only 50% of the general public prefer Thinking, and only 35% of women. If you prefer Thinking, therefore, there is a 50% chance that the patient in front of you will have a different preference to yours—that is, Feeling—and even greater chance if it is a woman. It is easy then to see that once you are aware of your own preferences, finding ways of adapting to those who are different could pay dividends in much of your clinical practice. The example in the box shows how quite minor adaptations can make a big difference. Figure 2 shows how you can adapt your style during consultations to suit the patient in front of you.

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Tips on . . .

Suturing skin

Suturing may seem fairly easy, and it generally is. Here are some tips for getting the best outcome.

Needle
- For suturing skin, use a curved cutting needle. With a straight needle you risk pricking yourself.

Suture size and material
- The bigger the number, the smaller the suture. For facial wounds, 5-0 or 6-0 is appropriate. Use 3-0 or 4-0 in areas of less cosmetic concern
- For skin, it’s usually non-absorbable (less scarring) but the stitches have to be removed. Therefore in children, absorbable sutures can be a less distressing option
- For skin, use monofilament (for example, nylon) since braided sutures can harbour bacteria

Technique
- You should not need to handle the needle with your fingers. Try to grab only the dermis—it’s less traumatic. Evert the skin edges to achieve dermal apposition—mattress sutures are useful if this is difficult
- For wide, gaping wounds, buried intradermal sutures (absorbable) can often make the skin closure easier and less likely to reopen later
- Don’t put too much tension on the wound as this can lead to local ischaemia and infection

Suture removal
- Cut under, not through the knot, and for mattress sutures, cut one strand or you risk leaving some behind. Always pull the suture out towards the wound
- Timing—there are no hard and fast rules, except that sutures should be removed at the earliest time judged safe. Most sutures can come out by seven to ten days. In the face and neck they come out earlier (three to four days)
- The wound should be supported for about a week after stitch removal. Steri strips or micropore tape work well
- Finally, remember the alternatives to sutures including staples, skin adhesives, and adhesive tapes. Staples are good when speed is required (for example, a bleeding scalp wound)

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