Specific Components of Bedside Manner in the General Hospital Psychiatric Consultation:

12 Concrete Suggestions

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The initial interview of the patient for psychiatric consultation in the general hospital often presents the clinician with daunting challenges. Patients are often very ill and confused and frightened, due to cognitive impairment and/or misinformation; they may not know that a psychiatric consultation has been requested nor why, and may feel threatened, embarrassed, and humiliated by the fact that a psychiatrist has been called to consult. The utmost in tact, compassionate empathy, sensitivity, and integrity are called for in such situations, to both treat the patients humanely and to obtain their full cooperation in the conduct of the consultation. In more than 20 years of conducting general hospital consultations, I have evolved a style of interview that, based on feedback from patients, housestaff who observe the interviews, and physicians who have requested the consultations, appears to be very effective in establishing rapport, eliciting the patient's willing participation, and obtaining the information necessary to provide a worthwhile consultation. An analysis of the components of this interview style suggests that the specific behaviors of which it consists can be precisely and operationally defined, and that each aspect is consistent with basic principles of humane care.

I present twelve behaviors as a list of do's, in some fashion analogous to the ten commandments for etiquette in the psychiatric consultation described by Pasnau.¹

Sit down: If physical arrangements permit, after introducing himself or herself and the reason for the visit, the consultant should ask the patient's permission to pull a chair up to the bedside and conduct the interview from a sitting position. Sitting reduces the status difference between physician and patient and the likelihood that the patient will perceive the physician to be assuming a lordly demeanor. Sitting also conveys to the patient the fact that the consultant has some time to spend and is not going to quickly dash off. Physicians who sit with patients are usually perceived by the patients to have been present for much longer periods of time than those who conduct their business from a standing position.

Do something tangible for the patient: Concrete physical
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gestures of helping, of the sort that a good nurse would instinctively perform, further the rapport: at the start of the interview, and whenever the situation arises during its course, the consultant should offer to be helpful in small ways: "May I get you a drink of water?" "Do you need to have your pillow freshened?" "Would you like your position changed?" Wiping a sweating brow with a towel, removing a bothersome obstacle from a bed, or rearranging tubes or other physical impediments to increase comfort demonstrates to the patient that the consultant cares for the patient's current well-being, and is not simply in a rush to get answers and leave.

Touch the patient: A warm handshake, using two hands, is always indicated. If the patient does not seem to object, and if there are no cultural contraindications, the physician sitting at the bedside should keep a light but warm grasp of the patient's hand and keep his or her other hand lightly touching the patient's shoulder. The physical intimacy of touch is especially helpful with a frightened, dependent, and/or very physically ill patient of either sex and conveys a humane caring that can reduce the feeling of aloneness and alienation that so often occurs in large, often dehumanizing medical environments. Patients with the most severe physical illnesses, particularly elderly patients and those with cancer or AIDS, frequently receive far less physical touch than other patients, and far less than most previously received in their lives from loved ones.

Smile at the patient: Even in the most dire circumstances in which a patient is terminally ill or in severe discomfort by smiling at the patient in a warm and kindly manner. Even if you are not usually a warm person, act as if you were! The smile conveys a benevolent intention, which is appropriate in all circumstances and may reduce a sense of threat that the patient may feel in response to having been put upon by a psychiatrist. Even in those situations in which the patient is hostile, angry, and demanding, a smile may have a useful and disarming effect, and perhaps permit a foothold toward developing some degree of noncombative dialogue that may improve the ability to gather information necessary to formulate an intervention. Of course, the psychiatrist needs to be sensitive to those clinical situations in which, for cultural reasons, a smile, particularly a forced one, may be misinterpreted.

Begin by telling the patient what you know about his or her situation: By the time consultants first see a patient, they often know a great deal from the physicians requesting the consultation, the nurses, and the medical record about the patient's circumstances and about the reason for the consultation request. Rather than asking the patient to tell the story from the beginning, the consultant should start the encounter by concisely but completely reciting to the patient in plain, simple language what he or she has learned, essentially describing the key elements in the history as the consultant understands them and offering a preliminary formulation using whatever information has been gathered up to that point. The consultant should ask the patient to correct any misinformation, misperceptions, or misconstruing of the facts. The positive effects of this procedure are several: first, as the consultant has already learned at least some of the material, the patient is treated respectfully by not having his or her time wasted and by not being asked to go through the sometimes boring (for the patient) ritual of once again repeating information that has previously been given to caregivers. Second, the patient has the opportunity to correct distortions, to amplify on certain matters, and to provide new information as its need becomes evident. Opportunities for such feedback from patients to correct misperceptions on the part of the medical staff occur far too infrequently. Third, and most important, the patient can see that the consultant has already been thinking about his or her problems prior to the encounter and can assess the quality of the consultant's level of understanding and concern. Often, hearing a preliminary formulation from the consultant at this early point provides the patient with the first-ever experience of having a physician provide such detailed feedback or understanding. The formulations themselves may provide the patients with insights into their situations that they may have previously been unable to put together.
Ask the patient what his or her most pressing concerns of the moment are: If the interview is conducted with the patient preoccupied by a major fear or concern, about the consultation or anything else, the patient’s full attention and cooperation will not be with the consultant. Eliciting and dealing with the patient’s major concerns clears the air so that other necessary information can be used more effectively.

Ask in detail about the patient’s belief systems regarding the nature, cause, and prognosis of the illness or injury, and about the patient’s specific concerns about pain, disability, disfigurement, or death: Asking the patient about belief systems enables the consultant to tune in to the patient’s perspective and expectations of what he or she is confronting; it also creates opportunities for the consultant to correct misimpressions and provide education that may facilitate the patient’s cooperation with treatment. For example, the consultant may ask, “Even though your doctors are still trying to find out exactly what your problem is, and neither we nor you know for sure, what have you thought yourself about what is making you sick?”

Ask in detail about the patient’s family, major social roles such as occupation, and the impact of the current illness or injury on those relationships and roles: Since every patient is concerned about the negative consequences of illness or injury on loved ones and on the ability to maintain major social role functions in family, workplace, and community, inquiries about these issues conducted in a conversational manner, freely sprinkled with feedback comments, convey the consultant’s interest in the patient’s day-to-day human world. Such questions as “who are the important people in your family and the rest of your life, and how are they coping with your being in the hospital?” and “What are your major concerns about the impact that your illness or injury is having outside the hospital?” should be asked routinely, to help the patient understand that the consultant appreciates that these are always expected areas of preoccupation.

Ask about the specific personal characteristics, activities, and attainments the patient has achieved in life in which he or she takes pride, and find an opportunity to compliment the patient on these qualities: Many hospitalized, seriously ill patients are severely demoralized, often belittling themselves for being useless to their families, jobs, and communities. To add insult to injury, many patients also feel that their caregivers are ignorant about their personal lives and cannot appreciate their worth or the contributions they have made. The consultant should inquire about accomplishments in which the patient takes pride and find appropriate (not forced) opportunities to compliment the patient on these achievements, with the intention of bolstering the patient’s self-esteem and providing the patient with the perception that the consultant appreciates him or her as something more than simply a dependent creature.

Acknowledge the human plight in which the patient finds himself or herself: Illness and injury are the great equalizers, and it is often strengthening to the physician-patient relationship for the patient to hear the consultant state in a matter-of-fact manner that, faced with similar circumstances, he or she might well display similar psychological difficulties. The patient should be told that it is very human—and expected—to lose emotional control in the face of bearing severe pain, confronting death, experiencing major physiological upheavals, suffering cognitive deficits, or contending with physical and social disabilities—all extraordinary stressors. This acknowledgment from an authority figure is, once again, designed to legitimize and validate the patient, and to support the patient’s self-esteem.

Fully explain the need for and purposes of a mental status examination in an informative way, and involve the patient as an ally and coinvestigator: Just as a good neurological exam can be performed primarily through observation, a good mental status exam can be conducted largely in the same way, virtually unnoticed in the course of the interview. Patients often experience participating in a formal mental status examination as a humiliation. Too often there is a crude segue in the interview from history-gathering to the embarrassed statement, “I just need to ask you a few questions that we ask everybody.” Many patients
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interpret the mental status exam to imply that the consultant is looking for serious mental problems or thinks the patient may be crazy, but is not able to be direct and honest about it. A better approach is to involve the patient by directly stating the obvious from the beginning: "You know that a lot of people as sick as you are, who have gone through what you’ve gone through, and who are taking the kinds of medications that you’re taking, have trouble concentrating, and off and on may feel confused, forgetful, or that their minds are starting to play tricks on them—hearing things, seeing things, etc. Have you been experiencing anything like that?" If, after all the data available from naturalistic observation and patient report have been collected, additional specific aspects of formal testing still need to be performed, the consultant should limit testing to those examinations that are relevant. The patient should be enlisted as an investigative participant, with a clear explanation as to how he or she stands to benefit from fully cooperating: "Please give me a hand in figuring out whether your condition is causing any subtle thinking problems. If there are some problems, we will do our best to figure out what’s causing them and do something about them. I would appreciate your helping me with some tests to see how well you can concentrate, remember, and think about things. As we go along in your treatment, we can follow these tests, just as we do with blood tests." This approach puts the patient in the role of helper and removes the consultant from the role of inquisitor. The patient is much more likely to feel treated as a suffering equal than as a weird specimen.

Leave the patient with something concrete: After concluding the information-gathering aspect of the interview, the consultant should give back to the patient both a revised formulation or a confirmation that the original one was correct, and some sense of what the consultant intends to do with the information: share it with the physicians and staff who requested the consultation, recommend certain further diagnostic or treatment interventions, plan to return for further interviews, suggest medications, suggest transfer, etc. It is also useful here for the consultant to once again ask the patient for feedback—to assess just what the patient has actually heard and retained of what the consultant has said—and to get the patient’s opinion about the plan. Of course, the way in which such information is imparted must be determined by specifics of the clinical situation; a patient who requires involuntary psychiatric hospitalization and who would be an elopement risk if told this plan prematurely should not be informed about the plan until all the components of care are lined up to assure a smooth transfer. The patient should know something about what to expect, however. If the consultant intends to return he should either set up a specific appointment or, if physical settings permit, take the patient’s hospital telephone number to call before showing up for the next appointment. Calling the patient to find out if a follow-up visit can be conveniently scheduled for both parties is another humanizing act.

The patient who is hospitalized for medical or surgical problems is inevitably subjected to myriad assaults on his or her dignity and autonomy. The socialization of physicians, including psychiatrists, often inadvertently contributes to their acting in small and unintentional ways to further contribute to the patient’s feelings of dehumanization and alienation in the hospital. The suggestions offered above have all been “field tested” many times and are highly effective in increasing rapport and the likelihood of a collaborative, constructive, and mutually satisfying relationship between the psychiatric consultant and the patient. If the psychiatric consultant is unable to solve all of the interpersonal and systems problems in large medical centers that contribute to the dehumanizing experience, at least he or she doesn’t have to contribute to the problem.

Reference