Communication skills during the clinical examination of the patients

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ABSTRACT

Introduction: The clinical examiner's communication with the patient is essential for successful relationship. It covers all forms of the doctor-patient relationship, and its quality affects the outcome of the disease.
Purpose: The discussion and critical evaluation of the communication's importance in therapeutic practice through a critical review of the existing literature.
Material and Methods: A literature search was performed in Medline, Pubmed, Cinahl, Google Scholar databases and the Greek database Iatrotek, conducted during the period 1988 – 2012, with keywords relevant to the subject of this review.
Results: The communication between medical and nursing staff and patient must follow certain rules. As the time spent by the physician in the examination and updating of the patient increases, so does the satisfaction of the second, it is appropriate to develop policies aimed at detailed information on the progress of the disease and its treatment. Furthermore, it is worth mentioning the physician's comfort when he is dealing with giving news, especially bad news and the maintenance of patient's hope during making decisions for his health and his life. The mistakes during the communication between the examiners and the patients are usually out of ignorance or negligence not only by early-stage investigators, but also poorly trained examiners older, and neglect systematically during the physical examination of patients.
Conclusion: There is a growing need for informed patient and involved in the therapeutic process, so there is a great need for the therapist have communication skills.
Key words: communication, patient, therapist, clinical examination.

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INTRODUCTION

The best practice of "therapeutic" is certainly the physical examination of the patient. Regardless of the clinical specificity of each therapist, it's a must the complete per-system examination of the patient and in fact, as single set and not as a sum of organic systems. Only after this examination, the examiner will deal with the individual suffering system and organ for which the patient was admitted to the hospital [1]. It should be remembered that the integrated examiner, along with his rich medical knowledge, he should be the owner of an appropriate technical-skill for the approach and examination of the patient. This technical-skill is related to the way that the examiner will treat the patient, by the time he comes to the examine room. Furthermore, how he would accept him and address to him to encourage him to talk about the health problems that bother him or his fears that he has [2].

The patient often attends panicky; he is scared for his health that might get worse, and he has thoughts about the possibility of a deadly disease. We should not underestimate the patient nor ironically mocks the excessive and often irrational fears [1]. He must also be convinced that the symptoms that he experiences are not new to the examiner but common in everyday practice review. Furthermore, we must gain the confidence of the examined person and not disappoint him [3].

Since the time of Hippocrates, the method of collecting this information is based on the narration of the patient's symptoms seek, and the comments of the examiner at the meeting with him [4]. Monitors, the senses and the general appearance of the patient, his facial expression and the emotional reactions, growth and nutrition, position in bed, his movements, his speech and generally, the "body language," which contains a lot of useful information [5]. It is a skill and an art that requires skill, experience and time to completion. The great clinical Englishman Sir William Osler (1849-1919) said: «teach the eye to see, the finger to feel, and the ear to hear» [2]. The degree of objectivity of the clinical examination, after all, is determined by the experience of looking at it, his behavior and his ability to interact with the patient [6].

The purpose of this bibliographic examination is to explore the communication of health professionals with the sick during the clinical examination in the context of hospitalization, at a time in which the widespread use of technology in performance and handling operation's diagnostic and therapeutic interventions alienates people from each other, something that affects their interpersonal relationships.

METHOD OF LITERATURE REVIEW

The methodology followed was based on the literature search and reviewing research studies, carried out during the period 1988 - 2012 and learned from international databases Medline, Pubmed, Cinahl and the Greek database Iatrotek on communication skills of health professionals during the clinical examination of the patient during hospitalization.

COMMUNICATION WITH THE PATIENT

Communication is the beginning and end of each contact with the therapist with the patient. This communication concerns the general information, information, therapeutic and, of course, the legitimacy. Any refusal or omission to this obligation may well be a medical error triggering civil, criminal, and disciplinary responsibility of the therapist [7].

The quality of communication strongly influences the willingness of the patient to comply with the procedures of the treatment and test new treatments. The two key ingredients that lead to patient satisfaction include the ability of the patient to understand and memorize what the therapist says [8].

The clinical examiner communication with the patient is essential for the harmonic and successful relationship. It covers all kinds of doctor-patient relationship, and from the quality of the communication affects the outcome of disease. According to validated studies when the process is done in the right way it has the therapeutic effect on the patient and affects patient satisfaction, his attention to the doctor and his understanding of medical information [9]. Since the more time is spent by the physician in examining and informing the patient, the greater the satisfaction of the patient is, it is appropriate to develop policies aimed at detailed information on the progress of the disease and its treatment. According to Steven and Douglas (1988), the patient-physician communication and disease awareness are equally important determinants of satisfaction, as the access and availability of services [10].

Several studies have shown that examiners and patients have their own opinions about what makes a good and effective communication [11]. These differences affect the quality of the interactions between them, as well as the compliance, the patient education, and the health outcome [12]. The way in which the examiner passes the information to the patient is as important as the information conveyed to him. Patients, who understand their therapists, perceive their health problems better, and they follow consistently the program of their medication [13, 14].

THE COMMUNICATION IN THE AGE OF MODERN TECHNOLOGY

The notion of a point related to the health status of a patient or referring to a morbid state is considerably subjective. And in order to approach objectivity, it is necessary to use other methods or specific diagnostic tests, which are more objective [15]. In recent years, to solve the diagnostic problems which are located near the clinical examination, the technology is used such as PC (computer), machines with large-capacity recording, storing, processing and combining a big amount of information. In the hospital, the computer helps to register any new examination or information, in order to be immediately accessible to the responsible clinician from the system terminal. [16].

Maybe someday in the future can make accurate diagnoses and recommend excellent treatments but never could empathize with the patient. The computer will never be able to substitute the therapist in this role. These facts are well known by the patient and for this reason, he refers to the doctor for help and not to the machines! [1].

So, in this era of high technology, clinical examination of the patient confirms the undeniable value since the computer does not contribute significantly to the reduction of uncertainty that comes as a result from the "signs" and "symptoms" of the disease, and the complexity of the logical process required for the estimation of so many data [16].

The diagnosis of a disease focusing solely to the computer, fails to handle the specialties of each patient who is always unique. For example, a decision for angiography for a person of 50 years and another 80 years with the same symptoms can't be based on the same criteria [17].

The reasons after all why patients resort to the Internet are many. One of them is the lack of information from health professionals in the health problem that concerns them. According to the results of a study carried out in Greece in a sample of patients with cancer, it is found that although patients want and need information, the amount of information they receive is inadequate. More than half (59%) did not know the diagnosis, while a large proportion had not been informed at all about alternative forms of treatment and did not participate in deciding on treatment followed [18].

ERRORS IN COMMUNICATION WITH THE PATIENT

The "mistakes" during communication between the examiners and patients are usually out of ignorance or negligence not only by newbie's examiners, but also from poorly trained older examiners, since they systematically ignore during the physical examination of patients, the process of searching existing points that they already exist, such as the existence clubbing. These facts are mainly due to omissions during searching certain physical signs in clinical examination, such as non-conducting rectal examination and palpation of the prostate. These errors were corrected using plan form clinical examination in the package hospitalization of patients [2].

The insufficient training of examiners to the "technical" approach and examination of patients leads to a non-specific finding despite his research. This is often perceived by the patient, who loses his confidence to the examiners. Moreover, incorrect assessment of physical signs leads to erroneous assessment of the situation of the patient. So we require relevant experience in the recognition and interpretation of these points, which is obtained after a long exercise in physical examination and under the guidance of experienced clinical teachers [1].

Fatigue and stress to the examiner may drive him inadvertent errors that will have unpleasant effects on the patient. The exhausted physically and spiritually examiner is dangerous both for the patient and for himself [3].

Moreover, during the clinical examination, many examiners have "poor" description, which is not conducive to developing a climate of trust with the patient. After all, it is prohibited to the examiner to wear bracelets, rings, etc., because there is a risk of transmission of microbial infections in sick. This behavior has been condemned even by Hippocrates, who writes in the "on efschimosynis" Capital: "As to the other (the doctor) must be clean, dressed decently and not babble ..." [4].

Particular attention also, during clinical examination, acquires behavior of examiners. Sometimes examiners, to obtain the necessary information from the clinical examination, create difficulties, which with little sensitivity can be avoided. But inflicting pain, other unpleasant experiences and to attack the moral values of the patient can and should be avoided, because they are disturbing the relationship between patient-examiner.

What also is unacceptable behavior, the examiner is to show that indifference, belittle, despise mocks or scorns the patient due to appearance, poverty, ignorance or inadequacy. It is therefore, unacceptable for the examiner to reveal discomfort about the problems of appearance of the patient, such as poor clothing, lack of cleanliness clothes or body, exhalation and odor [1].

Most complaints from patients and their families are related to communication problems like, for example, that therapists do not listen to their patients, although this is now considered fundamental to the modern medical procedure [12]. This whole process makes the patient responsible to

develop cooperation with the therapist, reduces stress and increase's confidence in him [19, 20].

Certainly, the information is not straightforward, and the needs are different in each case. However, this aspect of the patient-therapist relationship is difficult to determine, and effort and willpower can strike the right balance of a truly therapeutic relationship. This therapeutic relationship will also be the basis for a quality health care [21].

CONCLUSIONS

In this day and age, where there is a growing demand of patients for more informed and involved in the therapeutic process, the therapist is primarily responsible for meeting the needs of patients. The dispersion also of medical information from the media not always correct and accurate manner and the easy access to the Internet, have made the patient more informed, but also more demanding towards health personnel. The complete scientific training, therefore, the continuous training and proper communication technique will help them respond adequately, but with humanity, the expectations of their patients [4]. The study of the literature also shows that health professionals as health professionals who are actively involved in the treatment and care of patients, make basic and specialized knowledge in the design and implementation of nursing and therapeutic interventions, taking into account the information and messages given by the patient with verbal communication conciliation, capturing thoughts and feelings and generally with every expressive way [8, 22]. Furthermore, the support from health professionals and exercise counseling for patients and their families is a major and necessary for their therapeutic course and restore their functionality.

Conflicts of interest
The authors have declared no conflicts of interest.

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