Recognizing and Adjusting to Barriers in Doctor-Patient Communication

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Barriers frequently develop in physician-patient encounters. If they go unrecognized, they can severely limit the therapeutic potential of the doctor-patient relationship. Because barriers are not always explicit, a strategy is presented for recognizing implicit signs such as verbal-nonverbal mismatch, cognitive dissonance, unexpected resistance, and physician discomfort. Once a potential barrier is identified, its source can be defined and explored using standard clinical reasoning techniques such as hypothesis generation and testing. Patients can often share in the process of generating hypotheses about the nature and sources of barriers. Once defined and understood, most barriers can be lessened and sometimes resolved using the basic communication skills of acknowledgment, exploration, empathy, and legitimation. When conflict exists, common interests and differences must be clarified. Conflict might involve disagreement about the presence of a barrier, its nature or source, its relevance to the physician-patient relationship, or about strategies for approaching it. Negotiation need not be limited to the initial positions, but can include creative solutions whereby both parties gain. The decision to confront a barrier depends on both doctor and patient readiness, as well as how critical the barrier is to the therapeutic process, and how amenable it is to change. By effectively uncovering and addressing barriers, the physician can often turn roadblocks to effective communication into means for enhancing the therapeutic relationship.

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Barriers almost inevitably develop when two people attempt to join together in the pursuit of common objectives. Because no two individuals are identical in terms of background, experience, mood, and expectations, the process of coming to know one another involves a series of potential roadblocks as differences are identified and worked through. Many times the flow is smooth, and differences enhance rather than inhibit the relationship. Other times, however, significant barriers evolve and, if not properly identified, explored, and compensated for, they can inhibit the creation of a therapeutic relationship. When the sense of trust, openness, curiosity, and respect needed to engage in this process (1) does not exist, its absence can impair the three functions of the interview: data gathering, establishing a therapeutic relationship, and implementing a treatment plan (2).

A barrier is broadly defined here as anything that blocks effective communication. If properly handled by the physician, barriers can often be overcome during the course of a successful interview. For example, a patient may test the physician's response to minor initial complaints before bringing up the real reason for a visit because of fear of rejection or humiliation (3, 4). The physician, by openly listening and accepting, may allow the expression of both the initial and the subsequent reasons, thereby circumventing a potential barrier of misidentifying the most important purpose of a visit (5).

I will begin by developing a strategy for recognizing when a barrier exists, follow with general techniques for defining and adjusting to potential barriers, and finally explore what to do when barriers cannot be overcome. In Appendix Table 1, I develop a taxonomy of potential barriers along with initial strategies for physician response.

Recognition of Barriers

Explicit and Implicit Barriers

Sometimes a barrier is painfully explicit, although its roots and potential resolution may be somewhat unclear. For example, a physician might be accused of being "sexist," "racist," or "too young." The physician's creativity may be challenged to work through and resolve explicit barriers, but their existence is clear. More insidious are implicit barriers–those that are unstated and not obvious on the surface of the interaction. These barriers are quite prevalent in complex medical encounters that have a wide range of potential transactions. A simple example of an implicit

Table 1. *Possible Indirect Signs that a Barrier Exists*

Verbal-nonverbal mismatch
Cognitive dissonance
Unexpected resistance
Physician discomfort
Noncompliance
Treatment not working
Exacerbation of chronic disease

barrier is the fatigued patient whose physician extensively explores for thyroid problems, liver disease, or "viral illness" without discussing the possibility of depression or life stresses. The physician tells the patient that it "doesn't sound serious," and that no follow-up will be needed if the tests are negative. Here the physician's limited knowledge about the differential diagnosis of fatigue provides the barrier to fully exploring the patient's problem. Another example of an implicit barrier would be the patient with shotty lymphadenopathy who fears having the acquired immunodeficiency syndrome, but does not feel comfortable discussing these fears with his physician because he feels ashamed and also does not want to risk ridicule.

Indirect Signs

Several indirect signs in the interview may provide a clue that a barrier is present (Table 1). One of the commoner barriers is what might be called a "verbal-nonverbal mismatch" (6, 7). A patient, when asked about possible family problems, might say that "things are fine at home" while simultaneously reaching for a tear at the corner of his eye, looking downcast and sad. These are vivid demonstrations that what a patient is saying and what he is feeling are in conflict. The patient may not feel comfortable or safe discussing these problems with his physician, or the patient may be unable to acknowledge the underlying feeling to himself. Thus the presence of a verbal-nonverbal mismatch or any of the other indirect signs of barriers tell the skilled interviewer that an implicit problem may exist and that she will have to use skillful interviewing techniques to help define and accommodate to the barrier.

Other indirect signs of barriers are cognitive dissonance, unexpected resistance, and unexpected emotional discomfort on the part of the physician. Cognitive dissonance refers to the experience of the interviewer when trying to integrate information that just does not "add up," perhaps somehow defying common sense or common knowledge. For example, a patient does not feel well and denies any psychosocial problems or "stress," yet has recently had a death in the family, been divorced, and is overworking. Unexpected resistance might be further evidence of a barrier. In the just-mentioned patient, when the physician empathically acknowledges that the patient has certainly "been through a lot," the patient angrily responds that these life stresses are not relevant to how she is feeling, and that she is sick and tired of having people "poking into" her personal life.

The presence within the physician of unexpected feelings may also be a clue to an unexpressed barrier (8). Although such feelings may emanate from the physician's own conscious or unconscious reaction to the patient or the patient's problems, often the physician is nonverbally picking up how the patient is feeling. Thus the physician's feelings of anger or defensiveness may be the first clue that the patient is subtly demeaning, controlling, or attacking the physician's authority, even though the surface conversation is apparently affectively neutral. Defensiveness may also be a sign that the physician is confronting one of his or her own personal barriers. For example, a physician might have strong negative feelings about a patient with alcoholism because of his feelings toward his own alcoholic mother or feelings of helplessness and impotence he experienced working with alcoholic patients while in training. Similarly, a physician's sense of sadness, fatigue, or helplessness may be the clue to unexpressed depressive feelings in himself or in the patient. Although the subject of countertransference is complex and beyond the scope of this article, two hypotheses should be considered when the physician experiences a strong unexpected emotional reaction: First, is he sensing a barrier within himself? If so, is it one he knows from previous experience or is it new? Second, is he sensing what the patient is feeling or reacting to what the patient is provoking? If so, why is it coming through so indirectly?

Sometimes the only clue that a barrier is present is that the treatment is not working. It has been reported that noncompliance with physician "orders" may occur 50% of the time (9, 10). Although some noncompliance issues may be caused by communication problems in the treatment phase of the interview, noncompliance often reflects unresolved conflict or barriers between doctor and patient. For example, the patient who fears impotence from antihypertensive treatment, but feels uncomfortable discussing it with his physician, has a problem more with communication than compliance as it is traditionally conceived. Similarly, a rural patient who believes his abdominal pain is the result of voodoo may be not able to benefit from traditional medicine until the physician understands the patient's attributions. When a patient with a chronic disease has an exacerbation, both physician and patient may often be tempted to attribute the change simply to a worsening of the underlying disease or a failure of the treatment, without exploring the possibility that problems may be developing at psychosocial levels. Either the physician or the patient or both may be reluctant about broadening a relationship that had been very comfortable for both in the past. Although a treatment that is suddenly not working may be a sign that the underlying disease is worsening, it may mean that problems or barriers are forming at other dimensions of the interaction.

Defining Barriers

Once the physician recognizes that a barrier may exist, he or she must use interviewing skills to define and

explore it (11, 12). When the source of a barrier is obvious (for example, when the patient is angry because the physician is very late or has been called out of the room several times during the encounter), the physician should proceed to the adjustment strategies described in the next section. However, when the barrier is implicit and its source unclear, the physician's task is to explore and further define it before proceeding with the interview. The time spent uncovering the problem at this stage will prevent a widening of the gulf between physician and patient, and save time and energy in the future.

Clinical Reasoning

The clinical reasoning process of analyzing the data, generating hypotheses, and testing them during the interview with the patient is an excellent approach to defining implicit barriers. The hypotheses attempt to define the interactional issue leading to the barrier. The first level of hypothesis testing is for the physician to consider whether the problem is primarily hers, primarily the patient's, or a result of their interaction. Often a careful, honest look will generate a hypothesis about the problem that proves correct and leads to adjustments that allow the barrier to be overcome or circumvented. The most explicit way to test a hypothesis, particularly if it suggests that the problem is the patient's or a result of the interaction, is to share it with the patient.

For example, consider an urban physician meeting with a rural patient who seems to be reluctant to talk. The physician senses that the patient's beliefs about causality (fears about having been cursed) may be different from her own (dominated by Western medicine) and that the patient is afraid to discuss his real fears because of the cultural barrier (13). The physician could test her hypothesis in an open-ended way first by asking something like, "I wonder what your ideas are about why this is happening to you." If the patient responds with a verbal-nonverbal mismatch (denying any ideas, but looking engaged and somewhat frightened), the physician might push further by explicitly asking, "Some of my patients have had experiences with voodoo and I was wondering if that has crossed your mind?" By carefully noting the patient's verbal and nonverbal responses to this process of hypothesis testing, the physician collects data with which to accept or reject the hypothesis. By exploring the patient's beliefs and sharing her own, the physician tests the hypothesis. This exploration can help create a therapeutic bond based on a deeper understanding of their commonness and differences. Thus the process of openly and nonjudgmentally exploring the source of the barrier is the first step toward overcoming it.

When interactions between doctors and patients are more complex, unraveling the origins of a barrier can be extremely challenging. Take, for example, the mixed feelings and multilayered potential barriers elicited by a patient who has been physically mutilated (14), or the patient angrily dying from cancer, or the "hateful" patients so well described in the literature (15). When barriers develop in these interactions, separating and defining the unique contributions of the patient and the physician is a significant interviewing challenge, because it requires that the physician be self-aware and honest about feelings and reactions that may not be part of an ego-ideal. However, defining and exploring these barriers is critical to the creation of a meaningful therapeutic relationship.

Open Exploration with Patients

Sometimes the physician senses that a barrier exists, but even after testing several hypotheses about possible sources (self, patient, interaction), he is unable to define or understand it. The next step is to open up the hypothesis-generation process to the patient. This step requires that the physician openly share what he is sensing as indirect evidence of a barrier, and then ask the patient's assistance in hypothesis generation and evaluation. ("I'm sensing you are unhappy with the direction I am proposing, but I am not sure why. Perhaps you could help me understand what is going on.") The term "brainstorming" is used to describe the process of hypothesis generation where the participants are asked to let their imagination loose, minimizing critical analysis at first, to generate the widest array of possibilities (16). When the list of possibilities is completed (and not before), the patient and physician then try to narrow it down. Together, they can often define barriers and plan how to adjust to them. Sharing responsibility for identifying and overcoming barriers can be the source of a mutually enhancing, adult-adult relationship between doctor and patient (17, 18).

Adjustment and Resolution

Communication Strategies

The process of openly exploring and defining barriers is also the first step toward their resolution. When the patient is aware of the barrier and wonders how the physician will handle it, the physician's willingness to openly acknowledge its presence and explore the surrounding feelings can be very meaningful (2, 12, 19). Take, for example, a patient who has had a radical neck dissection and is self-conscious about the resultant deformity. The physician's willingness to acknowledge the deformity ("When did you have your surgery?") and explore its current effects ("What is it like for you now?") can begin to create a therapeutic bond. The more the patient feels that his or her perspective has been heard and understood, the greater the potential for a therapeutic relationship. When strong feelings emerge in the exploration, the physician can then express empathy and legitimation, thereby further creating an environment of shared trust. Empathy is an attempt to put oneself in another's shoes, and feel the way they feel. ("I would feel pretty angry if I wasn't fully prepared for how I would look after the surgery.") Legitimation implies the physician's power as an authority figure and a person

Table 2. *Communication Skills Used by Physicians to Overcome Barriers in Doctor-Patient Relationships*

Recognition
Acknowledgment
Exploration
Empathy
Legitimation

knowledgable about medical matters to validate a feeling or reaction as reasonable and appropriate. ("I can certainly understand how you would feel that way. I think it's a very normal reaction.") These communication strategies have been described in more depth previously (2, 11, 12, 19) and are summarized in Table 2. They are critical to successfully overcoming many barriers, and in fact, can help convert an obstacle to communication into a means to broaden and deepen the therapeutic relationship.

Sometimes physician accommodations are quite concrete and intuitively apparent. For example, speaking loudly and slowly while the patient is looking directly at the physician is a logical adjustment to a patient with a hearing impairment. Other times, as with the previously cited example of the patient with a deforming illness, the accommodations require skillful exploration and communication that depend on the patient's unique experience of illness. Appendix Table 1 shows a list of initial accommodations to barriers that commonly occur.

When the barrier is primarily the physician's, she must weigh the benefit to the patient of explicitly acknowledging it, or of adjusting to it on her own. This decision depends in part on the physician's comfort and skill at sharing her own feelings and reactions with patients, but more importantly, on the effect of this sharing on the patient individually and on the doctor-patient relationship. A simple example is a physician feeling bored and detached with a patient whom she usually finds interesting. As the physician tries to understand the origin of these feelings, she realizes that she is not picking them up from the patient, but rather that they are her own–a product of overwork, lack of sleep, and stressful events in her own life. Depending on the patient and the nature of the relationship, the physician might openly acknowledge that she is exhausted, and suggest to the patient that the visit be more limited in time and scope than usual. Such an admission might make the physician seem like more of a human being to the patient, and might allow the patient to reciprocate some of the nurturing feelings he had received from the physician in the past, thereby enhancing their relationship of mutual caring and respect. Another patient, however, might be very threatened by this admission of humanness by the physician whom he regards as having "god-like" power and other idealized characteristics. Although it could be argued convincingly that such unrealistic expectations should eventually be worked through, the physician in this exhausted state is in no position to do so. Therefore, in this situation, the physician might adjust to how she is feeling by limiting exploration and simply working on the most pressing explicit problems that the patient presents, leaving the implicit problems and the "hidden agendas" to another time when the physician feels better.

Timing

There is an element of timing that determines when and how explicitly the physician acknowledges barriers. Some barriers are painfully obvious, but too sensitive to be directly explored. Whether the doctor's or the patient's sensitive feelings are being protected is often a difficult question to unravel. Take, for example, a young woman who has always prided herself on her appearance who came in with a large breast lump that was subsequently found to be breast cancer. She had been aware of the lump for over a year, but had hoped it would go away. She has just had a mastectomy and lymph nodes are positive. On the other hand, the physician's mother died of breast cancer, and he is a strong believer in early detection, including breast self-examination. Both the patient and the physician feel a strong sense of loss complicated by confusing feelings of guilt, anger, and sadness. The potential barriers are many and interwoven, including a stigmatizing illness (loss of a breast), unexpressed emotions, uncertainty about the future, and complicated thoughts and feelings about responsibility and blame. In the face of these barriers, the doctor and patient together must make decisions about further treatment and about how the patient can adjust to this loss and regain a sense of optimism and hope for the future. Barriers are often complex, and the pace at which and sequence in which they are addressed are determined by the patient's readiness and the physician's ability to work them through. The physician may have his own set of barriers that also need to be paced and slowly resolved, sometimes with the patient (when appropriate), sometimes with a trusted colleague, and other times, particularly when the barriers are persistent and interferring, with the aid of a skilled psychotherapist.

Negotiation Strategies

Sometimes barriers cannot easily be worked through, and can interfere with the creation of a therapeutic alliance. In this situation, the barrier's existence is not at issue, but the doctor and patient may be at odds about its exact nature or how to approach it. The communication skills outlined in Table 2 have been unsuccessful at resolving the conflict. Here explicit negotiation is sometimes helpful (16, 18, 20). An overview of this approach is presented in Table 3.

Table 3. *Negotiation Strategies Used to Resolve Conflict in the Physician-Patient Relationship**

Separate people from the problem
Clarify the conflict
Brainstorm about possible solutions
Focus on common interests, not positions
Use objective criteria where possible
Invent new solutions where both parties gain

* See reference 16.

I will illustrate the strategy by the example of an anxious patient with irritable bowel syndrome who has been extensively tested and treated with no improvement in the diarrhea or cramping. Both doctor and patient are frustrated by her lack of progress, and this sense of frustration is preventing them from having meaningful, direct communication. The conflict has boiled down to a difference in opinion about the role of psychosocial problems in the illness, which the patient angrily and steadfastly denies. ("You'd be frustrated too if you had uncontrolled diarrhea.") The physician's strategy is to separate the people from the problem by suggesting that they are both frustrated by her persistent bowel problem (not by each other). He attempts to clarify the conflict by asking the patient to discuss her frustrations openly and fully and by doing so himself. In the process, the physician learns that the patient feels she is being accused of being a hypochondriac, and that she feels the physician is not taking the physical side of her ailment seriously enough. The physician openly expresses belief in the interaction between mind and body in this illness, and acknowledges that his frustration over the patient's unwillingness to explore the psychosocial dimensions of her illness may have led to a lack of emphasis on the physical symptoms. They establish a common interest of making the patient feel better and lessening her symptoms, but the physician acknowledges that many times this problem is life long, and helping the patient adjust to it rather than "curing" it may be the best he can offer. Such conversations where conflict is openly addressed and explored often facilitate the process of overcoming barriers, although many deep-seated barriers such as this can only be fully addressed over time in the context of a long-term, consistent doctor-patient relationship.

Limitations

Although it is appealing to believe that all barriers can be overcome with skilled communication, a strong therapeutic bond, and enough time, some barriers are immutable and others can be adjusted to, but not overcome. A patient with rapidly deteriorating Alzheimer disease, for example, will have a progressive barrier to meaningful verbal communication despite the physician's best efforts to compensate. The physician can help to limit the devastation by continuing to have regular meetings with the patient, exploring both verbal and nonverbal methods to maintain contact, and by communicating with family members and other healthcare providers to try to maximize the patient's quality of life. However, the principal barrier–the patient's organic brain syndrome–continues to progress, and the physician's compensation is explicitly designed to minimize the patient's losses.

A more complex example is a patient with a congestive cardiomyopathy who continues to smoke and drink alcohol despite the physician's advice. The physician is aware that many complex psychological and social factors are involved, but the patient is steadfast in his refusal to explore these areas. When the communication strategies listed in Table 2 lead to an angry response that threatens the doctor-patient relationship, the physician tries to negotiate the ground rules for the relationship. The patient's position is that he wants a doctor to take care of his heart and nothing else. The physician counters that the patient's heart problems are connected to his problems with alcohol and smoking, and cannot be viewed in isolation. The patient is unwilling to compromise, and says he will find another doctor if the physician is unwilling to care for him under the patient's terms. The physician's choices here are relatively limited. He can accept a limited relationship with the patient, in the belief that caring for the patient's heart in isolation is better than no care, and perhaps hoping that the barrier will become less rigid over time. The other option is for the physician to consider terminating the relationship, believing that with such a limited contract he cannot be helpful to the patient. Discussing termination should not be a common negotiating strategy for physicians. It can jeopardize the entire relationship, perhaps forcing the patient to accept the physician's position prematurely, or else to leave the relationship before adequate time has been spent working through complex barriers. There are some circumstances, however, where barriers are so profound, inhibiting, and persistent that termination becomes an important option.

Physicians enter into many limited relationships with patients where barriers are walled off and worked around. The decision to confront them depends on the willingness of the physician and patient to do so, as well as how critically the barriers are impairing the therapeutic process and whether they can be changed.

Taxonomy of Specific Barriers and Adjustments

A taxonomy of specific types of common barriers is presented in Appendix Table 1, divided somewhat arbitrarily into categories. Each barrier is associated with situation-specific suggestions for initial physician response. The taxonomy is not intended to be exhaustive, but rather to give the reader a sense of the range and types of barriers that might exist between patient and physician, and a general notion of how each might be approached. The adjustments are oversimplified, showing how the sometimes complex process of compensation might be initiated. Real-life barriers often do not appear in isolation, but rather in combinations that are often unique to the particular physician and patient involved. The process of defining and exploring these unique barriers with patients is often a key part of the therapeutic process, enhancing the doctor-patient relationship and often helping it achieve its healing potential.

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Appendix Table 1. *Taxonomy of Barriers to Physician-Patient Communication and Examples of Physician Adjustments**

Barrier	Adjustment Examples
Environmental	
Room access, privacy, noise, cleanliness	Ensure that the room is safe, comfortable, and private.
Body position	Allow appropriate distance-closeness, maintain eye contact, keep at similar height.
Note taking, chart reading	Keep to a minimum while interviewing.
Physical	
Pain or other discomfort	Start interviews by asking how the patient is feeling right then; acknowledge and try to relieve discomfort; note and explore nonverbal expressions of discomfort.
Fatigue	Identify the source of fatigue and consider limiting the visit.
Sensory deficit (deafness, blindness)	Identify and acknowledge early in the interview, and make specific adjustments to ensure effective communication and comfort†.
Organic brain problems in processing, recalling, or expressing thoughts and feelings	Carefully define through the interview, the mental status examination, or psychophysiologic testing, or a combination. Acknowledge and explore the accompanying frustration.
Psychological	
Emotions	Provide emotional support, including acknowledgment, exploration, legitimation, and empathy (2, 11, 12, 19).
Anger	
Sadness (helpless, hopeless)	
Anxiety	
Fear	
Shame (20)	
Attraction	
Euphoria	
Deprivation (sleep, sex, love, support)	
Cognitive and interpersonal	See general communication and negotiating strategies outlined in Tables 2 and 3 and explored in the text.
Denial	
Prioritization of several intermixed problems and feelings	
Dependency	
Responsibility or blame	
Uncertainty	
Lack of personal attention	
Personality style	Adjust physician style to the patient's personality‡ (21).
Mental disorder	Keep alert to possible co-existence of mental and physical disorders, to the unusual way psychotic patients may present physical symptoms, and to the high background prevalence of anxiety, depression, and alcoholism (22-24).
Sociocultural	
Other people involved	Protect the patient's privacy and confidentiality; obtain patient's permission and assess the overall effect on the individual patient.
Family	
Appointment not self-made	
Translators, facilitators	
Insurance companies, HMOs	
Legal processes, disability determinations	
Conflicted physician roles	Ensure that the other physician roles do not interfere with the primary role as personal physician and patient advocate.
Personal physician as opposed to gatekeeper (25)	
Investor in tests, hospitals, forms of reimbursement	
Physician's own value judgments	
Physician self-care as opposed to patient care (26)	Physicians must take better care of themselves.
Socioeconomic	Make reimbursement issues clear and explicit. Balance personal economic issues with societal obligations.
Rich or poor	
Form of payment	
Health insurance	
Language (27, 28, 29)	Avoid technical terms, check understanding and meaning of any diagnostic labels, and establish a shared language and understanding. Diagnostic labeling can resolve or create barriers.
Technical terms	
Translators	
Labeling	
Dress	Recognize that physician attire influences initial patient response. Power differences and vulnerability are exaggerated when patients are undressed.
Physician	
Patient	
Disrobing	
Stigmatizing problems (4, 14)	Acknowledge, explore, and empathize with the feelings of shame, worthlessness, and hopelessness often associated with stigmatizing illnesses.
All diseases to some extent, especially the acquired immunodeficiency syndrome, mental illness, and cancer	
Disfiguring illness	

Appendix Table 1. *(Continued)*

Barrier	Adjustment Examples
General doctor-patient differences Age Sex Race and culture Education Experience	Openly explore when problematic.
Cultural differences (13, 30, 31, 32) Beliefs about health and illness Attitudes toward risk and uncertainty Rituals, roots, superstition Religion Ethnicity	Explore and understand these differences in order to establish meaningful physician learning and a strong physician-patient relationship.
Transactional conflict (20) Problem-label Goal-expectation Method of diagnosis or treatment Conditions of treatment Doctor-patient relationship	Once properly diagnosed, try the negotiation strategies outlined in Table 3 (16, 18, 20).

* Numbers in parentheses are references.

† For example, the adjustment for a deaf person might be to speak loudly and slowly, clearly enunciating to facilitate lip reading, or perhaps to use a translator if basic adjustments are inadequate.

‡ For example, allowing a patient with a type A personality to exert more control on the treatment process than other patients who are more comfortable with dependency.

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