Are your patients’ emotions blocking their understanding?

Susan Quilliam

Introduction
It must have been 3 weeks ago that – for professional rather than personal reasons – I found myself in the waiting room at my local family planning clinic. Bright, friendly, well equipped: the place is a model of good practice.

So why was the woman patient seated in the corner becoming more and more distressed? She’d been asked to fill in a short form, and had then sat staring into space for several minutes before slamming the sheet down on the counter and saying angrily: “I can’t do this”. I wondered what was going on. The receptionist, however, knew exactly what to do. “That’s fine … why don’t we do it together”, she said. For the patient, relief.

And for me, enlightenment. Because it wasn’t that this woman wouldn’t fill in the form. It was that she couldn’t; she literally didn’t understand what was being asked of her. With the receptionist’s help, patiently and kindly reading out each question, and filling in the answers, it got done. Without that help, this woman was tipping over into anxiety, frustration and embarrassment.

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What was clear to me was that this wasn’t an isolated incident; the helpful receptionist was used to her distressed patient’s response. And it won’t be news to Journal readers that health practitioners need to deal with a stream of such non-comprehension issues on a daily basis. But the question I found myself asking was ‘Why?’. What creates these issues of non-comprehension? What makes our patients so unable to understand?

Lack of skill
Aside from situations where a patient doesn’t speak English – a vital problem but not directly relevant to what I’m considering here – the obvious explanation of lack of comprehension is that a patient may be illiterate. Elsewhere in this issue of the Journal1 there’s a fascinating paper on illiteracy, exploring this issue: the key point, however, is that illiteracy in this issue of the Journal1 there’s a fascinating paper on illiteracy, exploring this issue: the key point, however, is that illiteracy is more common than we may realise.

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While figures vary from country to country, 16% of the adult population in Britain is functionally illiterate. Which means that on a normal day, up to five of your patients may not handle what you’re telling them, because they can’t interpret the signs. Perhaps their vocabulary isn’t broad enough to understand what you’re saying – and if you try to step round that by handing them a leaflet or referring them to the Internet, that will be of even less help. Whether because of a lack of innate ability, a lack of education or a lack of previous exposure to medical terminology and approach, they live in a world where the vocabulary that is commonplace in our world is literally a closed book to our patients.

Emotional state
And there’s an added problem – one that is also more common than we may realise. When we consider patient lack of comprehension we’re not just talking skill-based illiteracy, we’re talking what I would term ‘emotionally induced illiteracy’. A patient who is perfectly capable of understanding medical material in their everyday life will find their comprehension dropping in situations where they are distressed, for example, if they are anxious, frustrated, guilty or embarrassed. If their literacy level is low to begin with, then under emotionally negative conditions that comprehension level will plummet; even if it’s not, they will become less literate than they normally are.

And here, of course, we reproductive health practitioners have a real problem, because anxiety, frustrations, guilt and embarrassment are woven inexorably into our clients’ state as they walk into our consulting rooms. Whether they’ve come to have an intrauterine device fitted, a smear taken, a pill prescribed

Box 1: Seven strategies to ensure comprehension
- Never say more than three sentences before checking understanding.
- Look for signs of confusion such as pauses, vague glances, misplaced questions.
- Don’t check comprehension with a closed question (e.g. “Did you understand?”). Instead ask the patient to tell you what they’ve understood.
- Get your patient taking notes; then go through the notes with them, correcting errors and validating correct understanding.
- Get the patient to teach you what you have taught them.
- Encourage the patient to tape consultations; for vital consultations provide a recording for the patient.
- Particularly with chronic conditions, encourage the patient to keep a health notebook, validate them by using that as the starting point for future consultations.

Box 2: Seven strategies for emotional reassurance
- Look for signs of anxiety such as hesitation, tearfulness, unwillingness to end the consultation.
- Look for signs of frustration such as loud voice tone, impatient gestures.
- Once you sense non-comprehension, look to yourself: aim to be calmer, more relaxed, more accepting.
- Increase your signs of encouragement such as smiles and nods.
- Normalise the situation with comments such as “Yes, it’s difficult stuff isn’t it”, “Lots of my patients have trouble with this...”.
- Avoid blame in the consultation (e.g. “People who don’t use condoms are irresponsible”) as this will increase the patient’s stress level.
- Validate the patient’s general approach to health – and their specific understanding of sexual health – with phrases such as “Well done”, “That’s great”.

J Fam Plann Reprod Health Care 2006; 32(4): 257-258

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J Fam Plann Reprod Health Care 2006: 32(4) 257
or a vasectomy discussed, there’s a chance that they’re going to be in a bad emotional state before they even start.

I do believe that of all medical professionals, bar those who deal with terminal illness, it is those who work in sexual and reproductive health who most need to take into account ‘emotionally induced illiteracy’. The true non-comprehension figure for our patients is likely to be way higher than the 16% of functional illiteracy quoted above. That figure of five patients a day not ‘getting it’ could, for us, rise to more like ten or twenty.

Box 3: Seven strategies for effective verbal explanation

- Plan the information you need to give ahead of time, starting with simple concepts and working up to more complex ones.
- Pre-prepare scripts for the most common problems.
- Keep a stock of ready-made drawings of body parts to draw on; if you have a patient’s X-rays or scans, personalise the discussion by using those.
- Use a mixture of presentation methods: information, anecdotes, pictures, demonstrations.
- When the patient speaks, check vocabulary level and concept level; let that determine your vocabulary and concept level.
- Use metaphors at the patient’s level: saying ‘an erection is like a hydraulic pump’ won’t work if the patient doesn’t know what a hydraulic pump is.
- When making recommendations, be specific.

Lowering distress levels

This concept of ‘emotionally induced illiteracy’ has some huge ramifications, one of which is this. It’s tempting – and commonplace – to assume that the most important and therefore initial response to patient non-comprehension should be a practical one: to actively adapt our presentations, whether verbal or written, to suit low literacy levels. That’s crucially important – and the strategies proposed here (see Boxes 1–4) suggest many useful ways forward – but I would argue that it’s not the first step. We need to lower distress levels in all our patients – whatever their ability to speak, read and write – rather than assuming that good presentation is the answer in itself.

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Hence, the cornerstone of any plan to address patient non-comprehension in reproductive health needs to be a lack of judgementalism, a sympathetic attitude, a positive validation of the patient’s level of understanding (whatever that is) and whether it is caused by lack of literacy or lack of emotional resourcing. Sadly, as an advice columnist, I regularly get letters from patients who have felt (their phrase, not mine) “stupid and dumb” in the consulting room. If we can alter that experience, if we can help them relax and feel more competent, then they will automatically do better. If negative emotion reduces comprehension, then positive emotion will increase it.

Facing the issues

I’m not suggesting that given practitioner acceptance, previously functionally illiterate patients will miraculously be fully literate – though, of course, any validation will make them less ashamed of their lack of skill and so more able to seek and use help for the problem. What I’m suggesting is that first, the most effective starting point for dealing with any issue of confusion or non-comprehension in patients of any literacy level is awareness of the emotional underpinnings of that plus active emotional support. And second, I’m proposing that even the best-presented explanations and expertly written leaflets will fail if they aren’t informed by such awareness and support. Yes, it’s not easy. Given time pressures we may want – and need – to move on from a patient who doesn’t quite ‘get it’. We may want to believe that a patient’s nods – even if accompanied by nervous gestures and blank looks – mean they have understood our explanation of how to take the Pill. We may want to believe that a leaflet given at the end of a consultation will solve the confusion that a patient showed in our presence.

But I do believe that facing and addressing the issues of emotionally induced illiteracy will serve not only the patients but ourselves. I do believe that given a commitment to supporting patient understanding, we will over time not only find patients more able to use reproductive health services more effectively and wisely, but also more willing and more committed to doing so.

Reference