Communication and Ethics in the Clinical Examination

Sharon Onguti, MD*, Sherine Mathew, MD, Christine Todd, MD

KEYWORDS
- Communication
- Ethics
- Physical examination
- Clinical examination
- Autonomy
- Beneficence

KEY POINTS
- Effective patient-physician relationship is built on trust and sound communication skills.
- Observance and application of ethical principles is integral in this process.
- Recognizing barriers to effective communication and developing skills to address is essential in this process.

INTRODUCTION

At the heart of every effective patient-physician interaction is a relationship that is built on trust. Cultivating sound communication skills coupled with the awareness and application of ethical principles is integral to this process. One of the foremost challenges in competent practice is negotiating situations that arise at the bedside when such issues as patient autonomy, differing world views, honesty, and cost stewardship come into conflict. It is essential for health care providers to consider how to detect and prioritize these issues as they advocate for high-quality and patient-centered care.1

The following are different patient scenarios that simulate real-life cases we have encountered in our practice and the approach taken to help build an effective relationship in the setting of competing ethical priorities.2,3

CASE 1: THE RESISTANT PATIENT

You are on attending rounds and the team walks into Mary’s room, a 32-year-old woman who was admitted for an emergent hematologic condition. She has been at the hospital for 3 weeks. She is finally improving and is tired of getting daily assessments. You are about to start examining her and she sternly says, “I was seen by

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Department of Internal Medicine, SIU Medicine, Southern Illinois University, School of Medicine, 801 North Rutledge, PO Box 19628, Springfield, IL 62794-9628, USA
* Corresponding author.
E-mail address: sharon.onguti@gmail.com

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two other physicians earlier and I don’t think you need to examine me.” She is adamant about this and does not want to be touched.

**Competing Priorities**

1. Patient autonomy: We respect that this patient has the right to decide who to discuss her care with, and who can perform a physical examination on her. It is easy to empathize with her frustration over a long, complex, and tiring hospital stay.
2. Providing high-quality care: Although data gathered by other members of the healthcare team are helpful, physicians place the most value on observations made by themselves in person. Although we assume everyone is doing their best, the quality of data varies greatly with the experience and expertise of the examiner.
3. Impact on physician approach: The patient’s response may evoke a sense of rejection in the physician, which can lead to a suboptimal physical assessment. This negatively impacts the quality of care provided.
4. Honesty: To be paid for their services to a patient, a practitioner must perform a portion of the history and physical in person.

**Approach**

It is difficult to ethically override a patient’s authority unless they seem to be incapable of making decisions. In this case, the patient is simply frustrated with the routine of being a patient, and her refusal is understandable. A general appeal to be allowed to examine her would be asking her to submit to a hierarchy where her autonomy is less meaningful than the power that places the doctor “in charge” of what happens to her. This appeal could be successful in getting the patient to submit to an examination, but would be detrimental to the physician-patient relationship. Instead, a negotiation with the patient about the parts of the examination the doctor is particularly interested in verifying and why those would be important to her care could result in the patient rethinking their decision and allowing the examination to continue. In negotiating with the patient, it is important to acknowledge their frustration and provide reassurance of unwavering support. This requires a significant time investment; reorganizing the structure of rounds to accommodate this is essential.

**CASE 2: THE VERY INVOLVED FAMILY**

Lillian is a 75-year-old woman admitted with pneumonia and acute hypoxic respiratory failure. She has two daughters and a son who are always present in her room. They are close to their mother and demand to be involved in every aspect of her care. Attempts at performing the physical examination are met with resistance and a need to justify its importance to her children. The patient is decisional, cooperative, and gives consent to be examined without restriction.

**Competing Priorities**

1. Appreciating a patient’s support system: We want to respect the caring relationship of a patient’s family in the same way we have respect for the patient themselves, particularly when their actions seem to be well-intentioned.
2. Patient autonomy: Although understanding that patients often act as part of a family unit, we want them to be enabled to make decisions independent of the unit when necessary, particularly in matters concerning their own well-being.
3. Beneficence: Although acknowledging the role the family plays, it is important to recognize when their involvement contributes to a harmful environment by obstructing the course of care.
**Approach**

This scenario highlights how a family’s genuine care for the patient may create a barrier to quality care. It is important to take the time to explore potential reasons for the family’s resistance to the health care process and discuss the significance of performing key aspects of the clinical assessments separately with the family. In addition, given the patient’s ability to independently make decisions, it is crucial for the health care provider to be able to advocate for the patient’s decisions. In the instance where family resistance persists despite taking the necessary steps to optimize the patient’s environment one needs to enlist help from the hospital system in the form of the clinical ethics service or social work. These members of the team are often willing to help facilitate a family meeting where the boundaries of a better relationship are negotiated.5

**CASE 3: “PAIN MEDICINE–SEEKING BEHAVIOR”**

The overnight resident is presenting at morning report. It was a busy night and the last admission was Matthew, a 52-year-old man on hemodialysis who is complaining of abdominal pain. He had been seen multiple times in the emergency department with similar complaints in the past year with no identifiable cause. He was thought to be having pain medication–seeking behavior because he persistently asks for more pain medication. During rounds the patient is noted to be writhing in pain. On careful physical examination, he has an acute abdomen. Surgery is consulted and he is taken for emergent laparotomy, which reveals a gangrenous gallbladder and intra-abdominal abscess.

**Competing Priorities**

1. Patient autonomy: It is important to take patients at their word.
2. Avoidance of deception: We recognize that manipulative or deceitful behavior is a characteristic of patients with chemical addiction, and seek to avoid enabling addictive behavior.
3. Stewardship of health care costs: We seek to avoid repeating low-yield work-ups for patients with complaints that may be functional in nature.
4. Open mindedness/Nonjudgmental attitude: Patients with addictions or difficult behavior rooted in mental illness can receive poor care if their complaints are not evaluated conscientiously with each presentation.

**Approach**

When a patient is labeled as having “pain medication–seeking behavior” it introduces a stereotype that often leads to simple dismissal of their symptoms without objective evaluation. It is important to remember that these patients present with genuine pathologies as often as any other. The correct diagnosis and treatment of this patient were a direct result of the objective findings on the physical examination. This was crucial in achieving a positive health outcome in the context of a patient in whom we fear manipulation or deceit because of prior behavior. It is imperative to have a balance between a cautious and an open-minded, objective approach to patients labeled with a stereotype.

**CASE 4: THE ANARTHRIC PATIENT**

Jack is a 71-year-old man with acute Guillain-Barré syndrome who is now quadriplegic, intubated because of chronic respiratory failure, and anarthric. However, he
is cognitively intact and has decision-making capacity. His ability to communicate is limited to blinking.

**Competing Priorities**

1. **Patient autonomy:** We recognize that a patient’s capability to make their own decisions is not dependent on their ability to vocalize their decisions.
2. **Communication barriers:** The patient’s inability to verbalize results in an underestimation of his ability to communicate his wishes.
3. **Psychological barriers:** Emotional despair associated with a rapidly progressive quadriplegia that rendered a previously high-functioning, active adult suddenly bed-bound and on a ventilator affects the patient’s motivation to participate in the conduct of his examination.
4. **Physician’s perception:** Establishing meaningful connections with the patient in the absence of a two-way verbal dialogue is challenging. The sense of helplessness handling the unnerving “silence” in the context of visible suffering is difficult for the healthcare team, and may cause them to avoid contact with the patient.

**Approach**

This case demonstrates the challenges of achieving meaningful patient-physician communication in the setting of a nonverbal patient, and the potential for positive clinical outcomes and rewarding interactions if these challenges are directly addressed. The key is to explore innovative ways to boost the patient’s communication. In this case, the family devised an alphabet system that the patient used to describe his symptoms. This offered an opportunity to obtain more accurate and detailed information from the patient’s perspective. This also highlights the importance of involving family in the communication process. The impact on the patient experience was invaluable. Another aspect is recognizing the significance of nonverbal indicators, such as eye expressions, and the feedback they provide. On the first few visits, the expression depicted an extremely angry affect. Through the strengthening of communication, he later had an expression of satisfaction and deep gratitude.

**CASE 5: CULTURAL RESERVATION**

Rose is an elderly widow with no children, but many supportive members of her church visit her daily. She says that they have helped her a great deal since the death of her husband 6 months ago. Rose is hospitalized with new-onset atrial fibrillation and high-grade aortic stenosis. The cardiology service offers her a transcatheter aortic valve replacement and describes significant benefits and significant potential complications (eg, stroke).

Rose is having trouble making a decision. She frets and says “I can’t understand why the doctors won’t just decide if I should have it or not.” Her friends take the team aside and inform them that Rose “will never make a decision.” She was accustomed to her husband making decisions for her, and since his death, her friends have found it necessary to act in her best interests, discovering that she does not seem to have the ability to make a decision on her own.

**Competing Priorities**

1. **Patient autonomy:** We want to empower the patient to make her own decisions.
2. **Substituted decision making:** If the patient cannot or will not make decisions, we wish to ensure that she appoints/endorses substitute decision makers.
3. Protection from manipulation: We want patients to make decisions independent of factors stemming from the beliefs of their families, friends, or health care team.

**Approach**

When we think about patient autonomy, we often envision an isolated patient making decisions solely about themselves. However, people often make decisions as part of a family unit, and it is not unusual for individuals to sacrifice their own wants and needs for the betterment of their family. Culturally, women may be encouraged to put their family’s needs before their own and additionally expected to let their spouse or father make decisions for them. Patients who belong to a patriarchal family structure can be unequipped to make decisions about their own health. Although this patient seems to be able to communicate and discuss her medical issue, she is not able/willing to make an independent decision. Thus, we must use substitute decision makers to move forward with her care. It is likely that this patient could have a discussion with her care team about whom she would trust with medical decisions, and that she does have friends willing to step into that role. Appointing one of them as a power of attorney (POA) would be helpful in “making legal” the support system already at work in her life. In a case where a surrogate decision maker is not apparent, physicians must act in the patient’s best interest and document the patient’s inability to make decisions in the medical record.

**CASE 6: PHYSICIAN BARRIERS**

Alice is 65; she presents to the emergency department with a dissecting aortic aneurysm. She was critically ill, and unable to make decisions for herself. Her son, who accompanied her to the emergency department, met with the vascular surgeons. In his recollection of the conversation, they told him that the choice was to do nothing and let her die or to do a complicated and long surgery that would ultimately allow her to “walk out of the hospital.” He gave consent for surgery.

Although Alice survived her surgery, she had many complications including a spinal infarct with resulting paraplegia, acute kidney injury requiring long-term hemodialysis, and ischemic injury to her feet requiring bilateral amputations. Alice has not left the hospital since her admission 2 months ago. She is delirious, moans in pain, and frequently asks staff to “just let her die.” Multiple family meetings with her son to address goals of care are met with resistance. The son is angry, stating the hospital “said she was going to walk out of here and now you are going back on your promise.”

No one involved in her case from the vascular surgery team remembers making any such promise. There is no discussion of consent in the medical record, only a signed consent form for emergency vascular surgery. The surgeons have signed off, because she has no current active vascular issues they can remedy.

**Competing Priorities**

1. Honesty: The health care team wants to carry through on promises made to patients.
2. No undue suffering: We seek to alleviate as much pain and suffering for patients as possible.
3. Substitute decision making: When patients are unable to discuss plans and decisions with us, we seek to have a positive and productive relationship with appointed substitutes.
4. Apology: We seek to disclose and apologize for medical errors.
5. Responsibility: All members of the health care team must participate in building a positive relationship with the patient and family.

**Approach**

In this case, a surrogate decision maker is available, but does not have a positive relationship with the health care team. To discuss the patient’s needs, the relationship with the surrogate must first be mended. In some cases, the reason for mistrust or ill will between families and the medical staff is caused by misunderstandings that are corrected in a face-to-face conversation. Here, the issue seems to be a promise that was made that was not realized. It is important to highlight the devastating effect that promises, which physicians can make without much thought with the intention of being reassuring or persuasive, can have on a desperate family. As in this case, what the family hears and what the physicians recall saying often differ significantly in retrospect.

An apology and explanation from the physician or team that originally participated in the discussion would be best, but in complex cases, it is not always possible to identify who those people might be or to successfully ask them to apologize for an issue in which they do not believe they played a role. As the patient’s current doctor, you may need to apologize and explain “on behalf” of the teams that have participated in the patient’s care. You may want to discuss this conversation with the risk management team at your institution beforehand to get advice on managing the apology and discussion. An invitation to other teams to be present at a family meeting that you manage could encourage them to be involved in a positive way.

A script for the apology in this case could run along the lines of “When your mother was admitted, you were given the expectation that she would heal and walk out of the hospital. This is not what has happened. We want to acknowledge that and we apologize for it.” This apology opens the way for the family to ask questions that lead to open dialogue, a better understanding, discuss prognosis, and the way forward. In the past, physicians were counseled against apologizing for errors and outcomes for fear of legal liability. Recent literature shows that transparency about errors and bad outcomes and apologies are key points in avoiding malpractice litigation.7

**CASE 7: RACISM**

Your encounter with Eileen for the work-up of colitis is going well. At the end of your encounter, she thanks you. “You are the first doctor I have seen who speaks English!” she tells you, with relief. She requests that she not be seen by any “foreign doctors” during her hospital stay. “You know what I mean,” she explains.

**Competing Priorities**

1. Nonjudgement: We recognize that our patients have perspectives and priorities that differ from ours.
2. Patient autonomy: A patient has the right to control who is involved in their health care.
3. Honesty: The patient’s request is impossible to fulfill in the complex health care system.

**Approach**

It is not uncommon to hear a patient express or seek agreement with a sentiment that is offensive to us as providers. These moments are uncomfortable, and it is worth thinking proactively about how you will respond. A patient’s social views do not
subtract from their right to high-quality health care, but the health care team has a right
to work in an environment that does not threaten them.

It is incumbent on us to take care of our patients without regards to their personal
views. This requires us to find a way to truly care about people who we might not asso-
ciate with in our personal lives. The empathy required in this situation requires the
practitioner to find sources of alignment or similarity with the patient. Finding an
area of agreement with such a patient can be extremely difficult, but this challenge
is often the nidus of professional satisfaction and growth.

In regards to this patient’s request to see only a certain type of practitioner, educa-
tion about realistic expectations from the health care system is in order. It is not
possible for you to comply with the patient’s request given the makeup of the health
care team and the lack of control you and the patient has over what kind of care they
will need and when. Talking to the patient about this reality and sharing your viewpoint
on the value of your colleagues may help the patient anticipate and accept care from a
wider variety of people. This discussion also places the consequences of the decision
on the patient instead of the practitioner.8

CASE 8: AGAINST MEDICAL ADVICE

Jeff is a patient with diabetes and severe gastroparesis. To help with his nutrition and
stabilize his blood sugars, a nasal feeding tube has been placed and advanced to his
jejenum. Tube feeding is started but the patient has told the nurses he wishes to leave
against medical advice (AMA). The tube feedings make him feel bloated and give him
abdominal cramps. He plans to remove the tube, leave the hospital and “get better on
my own.”

Competing Priorities

1. Patient autonomy: We allow patients with decisional capacity to make their own
   choices, even if we think they are poor ones.
2. Public safety: We should act to restrain patients from leaving the hospital if they
   represent harm to public safety.
3. Future relationships: We want to act in such a way strengthens and improves the
   physician-patient relationship.

Approach

When patients threaten to leave AMA, it is important to determine their decisional ca-
pacity and whether leaving poses an imminent threat to either themselves or others. In
those cases, patients can be “incarcerated” in the health care environment. However, if
patients are able to articulate the possible consequences of leaving AMA and do not
pose a significant threat by doing so, a more supportive role is encouraged. Paramount
in these situations is the preservation of a positive doctor-patient relationship, so that
the patient feels empowered to care for themselves in the best way they can and also
welcome to return to the hospital/clinic if they change their minds about needing help in
the future. This might include writing prescriptions for outpatient medications at the
time of departure, a discussion about signs and symptoms for which you would
encourage a return to the hospital, and avoiding coercive language (eg, suggesting
that the patient’s insurance will not pay for their admission, a commonly used lie).9,10

CASE 9: SUBSTITUTED DECISION MAKING

Harry is admitted with chronic obstructive pulmonary disease exacerbation. He is
delirious, requiring bilevel positive airway pressure, and unable to make his own
medical decisions. His advanced directives name his wife as his POA, and are vague about whether or not he would want to be intubated in this situation. His wife is contacted and tells the team that she and Harry are separated and talk infrequently. She states he would likely want aggressive measures but not including intubation. Meanwhile, another woman arrives and identifies herself as Harry’s girlfriend. She states that since meeting her, Harry has a new lease on life and she thinks he would be willing to be intubated if his condition deteriorates.

**Competing Priorities**

1. Substitute decision making: We want to adhere to the decision makers appointed by the patient or delineated by laws, such as Healthcare Surrogate Acts, when patients cannot make their own decisions.
2. Transparency: We recognize that patients make decisions about health care in the context of predictions of future health crises. We understand that at any given time, health and family situations may be substantially different from those imagined when appointing surrogate decision makers.

**Approach**

Although advanced directives convey a sense of permanence, they are documents that patients can change their minds about and rarely contain explicit instructions about medical care. Therefore, when patients are unable to communicate with their health care team, it is important to obtain and read any documents pertaining to the patient’s wishes about care and substitute decision makers. Confirm decisions made on advanced directives with surrogates by discussing the current medical situation and how the patient's decisions apply. There may be circumstances that cause the surrogate to feel the patient would make different decisions than those previously documented. If the surrogate may not be acting in the patient’s best interests, advocate for the patient by adhering to their documented wishes and asking for support from colleagues or a clinical ethics service. A different surrogate may need to be appointed.

In this case, it seems that Harry’s life circumstances have changed since he appointed his wife as his surrogate decision maker. We cannot be confident that his wife knows how he would respond in his current situation. A discussion with both parties can resolve these conflicts; given their estrangement, Harry’s wife might agree to step down as POA and let his girlfriend be the surrogate decision maker. If the conflict cannot be resolved by a discussion with the competing surrogates, the health care team must act in the patient’s best interests. In the case of a chronic obstructive pulmonary disease exacerbation, where a terminal condition is not necessarily present, intubation should be initiated if required, in the hopes that the patient would recover and be able to make his own wishes known.

**SUMMARY**

In this article, we present a series of patients whose care was marked by frequently encountered barriers to effective and meaningful patient-physician communication. These barriers include those extrinsic and intrinsic to the patient and family dynamic. These barriers cannot be simply attributed to a single party in the patient-physician relationship; they arise in the vast backdrop of complicated medical, ethical, and socioeconomic issues within a rapidly evolving health care system prone to rendering patients and physicians dissatisfied by their experience. We demonstrate a guiding approach for the medical team to support and enhance the patient-physician
relationship through thoughtful self-reflection that begins with a key question: *What competing priorities are at stake?* This can help elucidate broader principles at play, remove blame from the equation, and unveil a strategy to break a barrier. Ultimately, we remember that patient-physician communication is an art that is human in its very essence: the meeting space of persons, imperfect at times, but always with the potential to transform what lies ahead into something shared and meaningful.

REFERENCES