42 Communication Evaluation in Psychosomatic Primary Care

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> The key to improving care for the mentally ill lies not in the generous expansion of psychiatric services, but rather in strengthening the primary care physician in his or her therapeutic role.
>
> Shepherd et al. 1966

Abstract: The increase in competence in psychosomatic primary care through participation in further education and training courses is examined on the basis of the accompanying evaluation of the curriculum, the participants' goal achievement forms and the basic documentation of treatment cases. Improving their medical interviewing skills was an important goal of participants and was partially to fully achieved in the overall assessment. Their improvement in communication competence also led to an increase in confidence in dealing with psychological and psychosomatic problems and job satisfaction. In the day-to-day work of

physicians, it is evident that conversation offers by physicians were readily accepted by patients, and that patients with accompanying conversations were more satisfied with the treatment in both the physician's and the patient's assessment. Patients rated the success of the treatment higher and rated the mutual understanding between physician and patient higher than patients without talk therapy interventions. A similar picture emerged with regard to the implementation of basic psychosomatic care in hospitals. The results prove that, from the physicians' and patients' point of view, psychosomatic primary care has achieved its goal.

42.1 Possibilities of evaluation of further education and training courses

The following options are available for evaluating further education and training courses in psychosomatic medicine:

1. Written questioning of participants during the course (formative evaluation) and at the end of the course on content, didactics and organization
2. Informal evaluation in the group after one third or halfway through the course with the questions: What is my current skill level? What would I still like to achieve? What am I finding difficult?
3. Goal attainment sheet for the participants (Goal Attainment Scale)
4. Working on sample cases using a standardized evaluation scheme
5. Basic documentation of treatment cases
6. Exam questions on diagnostics and therapy of mental and psychosomatic disorders and diseases
7. Evaluation of interviews with participants, regarding learning objectives, content, didactics and methodology and implementation in practice
8. Video recordings with standardized patient actors and blinded evaluation with a standardized checklist by external raters
9. Video recordings of the medical practice of the participants and blinded evaluation with a standardized checklist by external raters
10. Individual 1:1 feedback in the practice situation

The above items 7-10 are very staff and time consuming and are most likely to be used in the context of a third-party funded study. For a routine evaluation, the evaluation forms 1.-3. and 5. (Basic documentation of treatment cases), have proven best.

42.2 Evaluation of Psychosomatic Primary Care

Skill enhancement through participation in courses in primary psychosomatic care is presented using four studies:

1. Accompanying evaluation of the curriculum in psychosomatic primary care (written survey of the participants and informal evaluation in the group)
2. Analysis of the goals of the participants and the achievement of these goals (goal achievement questionnaire)
3. Joint project „Quality assurance in psychosomatic primary care of the German Ministry of Health“ (basic documentation of treatment cases)
4. Evaluation of the case documentation of hospital physicians (basic documentation of treatment cases)

In the following, three of the above-mentioned evaluation options and their results are presented on the basis of four projects on psychosomatic primary care.

42.2.1 Accompanying evaluation of the curriculum Psychosomatic Primary Care

The results of this evaluation are based on a 2-year further education program in the region of South Baden, Germany. It was developed, organized and realized mainly through the cooperation of the District Medical Association, the Association of Statutory Health Insurance Physicians of South Baden and the Department of Psychosomatic Medicine and Psychotherapy at the University Hospital of Freiburg. The concept, implementation and further results are published (Fritzsche et al. 1994, 1995, 1996, 1999, 2000, 2004, 2010, Fritzsche, Wirsching 1993, Stadtmüller, Fritzsche 1995).

Methods

In a questionnaire, participants assessed the informational value, practical orientation, and their satisfaction with the seminar lectures and small group work. In an additional questionnaire submitted at three points during the 2-year training, the physicians documented the impact on patient care and the work situation. The group leaders documented the progress of the small group work and described contents and problems during the case presentations.

Results regarding the communicative competence

Approximately 300 physicians regularly participated in the further training program. The age of the participants ranged from 27 to 64 years, with an average of 43 years. They had worked in private practice for an average of 7 years. The majority of participants were general practitioners (50%) and internists (25%). 67% of the physicians had a private practice. In their own practice, the proportion of patients with psychosomatic problems was estimated to be about 30-50%. It was surprising that half of the physicians were hardly or not at all interested in formal proof of participation for billing EBM figures.

In the second part of the course, participants were able to put their individual program together from disease patterns, treatment approaches, and general topics. The evaluation showed that, among the general topics, from 12 given topics, interviewing methods was in first place. From the group leaders' point of view, the main topic in all small groups was the problems and difficulties arising from interactions between physician and patient. Difficulties in dealing with one's own feelings such as anger, rage, disappointment, and helplessness were documented most frequently. Furthermore, patients were frequently presented who showed strong resistance to becoming aware of their own inner conflicts. It was discussed how to convince these patients that an indicated psychotherapeutic treatment could be useful for them. So-called difficult patients were repeatedly described, often with severe chronic illnesses such as anorexia nervosa, chronic pain syndromes, severe depression, or physical illnesses such as cancer or multiple sclerosis. These patients were experienced as aggressive, overbearing, reproachful, and easily offended. Possible responses were worked out by the group, such as helpful accompaniment, patience and empathy, but also

setting boundaries and protecting oneself from over-commitment or total withdrawal.

Patient care and the physician's work situation

The recognition of mental disorders, psychosocial competence in conversation, referral to specialist psychotherapeutic treatment and the possibilities of effectively influencing severity and course through talk therapy interventions, increased significantly in the participants' self-assessment. The most important results on the physician's side are the significant increase in their job satisfaction and the greater confidence in dealing with psychological and psychosomatic problems of their patients. The time spent per patient and the total working time stayed the same. We interpret this as an indication that psychosomatic primary care can certainly be integrated into the well-known, tight time budget of the practicing physician.

Compared to a reference group of 100 general practitioners and internists who did not participate in the training, the participants in the training prescribed significantly fewer medications on average. While the difference was relatively small before the start of the training, it became statistically significant towards the end of the training ($p < 0.05$). This trend continued considerably into the following year. The achieved savings when several quarters were combined, converted to the total number of participants, amounted to several million DM (former German currency) (Fritzsche et al. 1994).

Excerpts from interviews with the participants

In structured interviews, which were evaluated by content analysis, the physicians describe themselves as more patient than before the course. Furthermore, they feel more capable of listening to patients' problems, understanding them, enduring conflicts, and perceiving and expressing their own feelings. They see themselves as more competent in guiding conversations and are not afraid to ask the patient questions about their life situation and biography. They are also more successful in controlling the length of the conversation.

E 42.1	Conversation management and relationships

Example 1:
I can understand the patients better and have become more patient. I'm better at recognizing the problems and needs of the patients and can now hear with the third ear, which I could not before the course.

Example 2:
I reflect about my relationship to the patient and try to understand what kind of feelings the patient triggers in me. For years, I didn't perceive that at all. The advantage is that now you learn how to do something for your own mental hygiene. You become calmer and more relaxed about some things.

Example 3:
When you sit down and say, what feeling do I have about the patient now? Anger, disappointment, disillusionment or hatred or ..... Of course, there is often anger, or flight, flight thoughts; that you say, either I'm leaving now or I'm sending the patient away or other things. You have to try to fight that a little bit. That has already become more intense, definitely!

Excerpts from interviews with the participants

During and after the course, the physicians indicated that the percentage of time per patient and the total working time have hardly changed. Some of the physicians have extended the time cycle from 10 to 15 or 20 minutes. Others offer additional consultations in the afternoon or evening. Overall, the physicians have learned to better limit their own and the patient's talking time in the conversations.

E 42.2	The impact on the required length of time

Example 1:
The required length of time used to be much more excessive - measured in terms of effectiveness.

Example 2:
The way I deal with patients has certainly changed somewhat, also in terms of the time they rquire. The setting has become more concrete. Putting certain conditions on the patient, not wanting to have infinite time available for patients. For example, I say, I have 20 minutes for you and then you‘re welcome to make another appointment.

Excerpts from interviews with the participants

The skills learned not only led to better treatment outcomes for the patient, but also to greater satisfaction and positive personal development for the physician.

E 42.3	Relief and enrichment through psychosomatic primary care

Example 1:
No, it’s not a burden. On the contrary, I can only work in such a way that I also retain a certain satisfaction and joy from it and am not frustrated and dissatisfied in the long run. In this respect it is a gain. But it requires more effort. But I wouldn't see that as a burden. The required length of time used to be much more excessive - measured in terms of effectiveness.

Example 2:
I think we are both changing. I change the patient and psychosomatics changes me. I have become completely different since I started being interested in psychosomatics. I am much happier and calmer, more balanced, not as stressed as when I was a surgeon.

Example 3:
Both partners benefit. I myself am enriched by the conversational contact, and so is the patient. I would not be satisfied with myself if I just shook the patient's hand and asked "How are you?“.

Example 4:
That is a very big plus of psychosomatic primary care, that I have now learned that you don't always have to expect success. Psychosomatics is something that happens in very small steps. Take the whole thing a little more relaxed. Lean back sometimes, take a deep breath and then gain some distance. That you first have to push away this never-ending pressure, the need to succeed, that you push it far away! And that is actually something that has made me much more satisfied with the whole process.

Excerpts from interviews with the participants

42.2.2 Analysis of the participants' goals

Methods

The goal achievement sheet has predefined boxes which are filled in with the desired learning goals on the first day of the course. On the last day of the course, the sheet is handed back to the participants with the request to evaluate their own learning objectives with three categories (achieved, partially achieved, not achieved). An additional rubric can be used to indicate which learning objectives were newly added and also achieved. $N = 100$ participants completed the forms in full.

Based on the goals of primary psychosomatic care, known problem areas, and participants' goal statements from previous courses, participants' goal statements were grouped into the following categories: Recognition of mental problems, treatment, indication and referral to psychotherapy, physician-patient relationship, self-awareness, interviewing methods, organization. In the evaluation form, participants could indicate whether the goal was fully achieved, partially achieved, or not achieved. In addition, they could indicate which new goals were added at the end of the course.

Results

Examples of the goals obtained from the "goal achievement sheet" subproject are summarized in Table 42.1, where a total of five aspects and dimensions can be distinguished.

Recognition of psychosocial problems
Reliable classification of symptoms as organic or psychosomatic already in the first anamnesis
Raised awareness of mental health issues
Learn to read between the lines, training and sharpening perceptive skills
Other e.g. family history, attention to body language
Physician-patient relationship
Transference and countertransference
Recognize one's own mistakes in physician-patient interactions
Connection of empathy and competence in the sense of detached compassion
Protection against feeling overwhelmed
Self-awareness
Reduce insecurity about "psycho problems“
Own feeling as diagnostic
Increased self-perception
How do I appear to others?
Sensitivity for your own problems in family and profession
Treatment strategies
Learn about and apply treatment options for psychosomatic illnesses
Crisis intervention
What to do when someone decompensates over the weekend?
Treatment of chronic pain patients
Treatment of patients with physical complaints without organ findings
Dealing with problematic patients
Enduring aggression and anger
Dealing with oncological patients and patients in the dying process

Tab. 41.1: Participants' goals (Examples)

In addition to the recognition of psychosocial problems with 29%, the most frequently mentioned goal was the improvement of interviewing skills with 21%. Recognition of psychosocial problems, conversation management, self-awareness and physician-patient relationship were completely or partially achieved to a similar extent. Treatment options showed a significant difference to the other goals, in the direction of having been only partially achieved or not achieved (see Fig. 42.1).

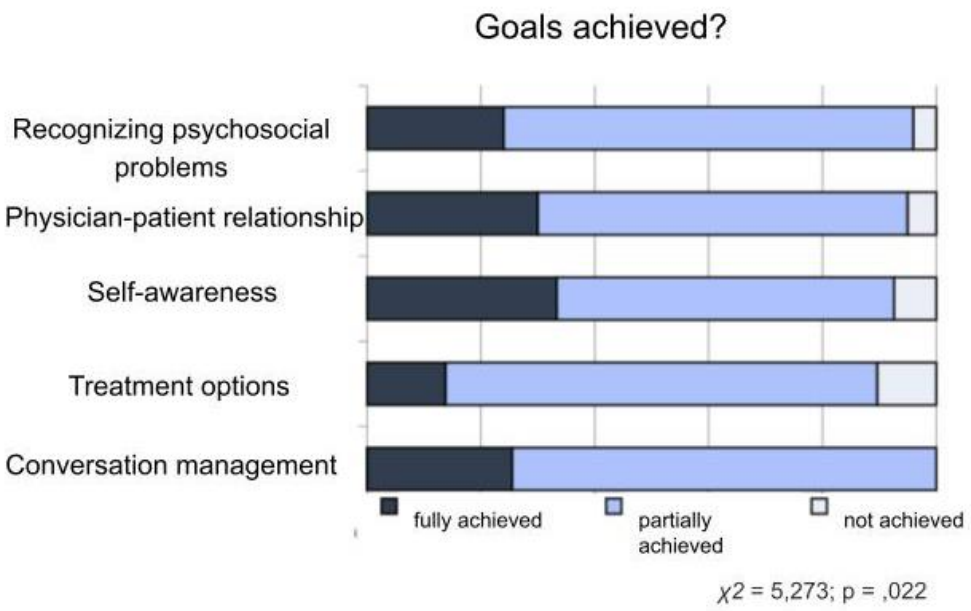

Fig. 42.1: Goals achieved

The assessment of the achieved goals is consistent with the experience of the lecturers and the results of the accompanying evaluation. The guidelines of the course, namely to provide a balanced combination of knowledge transfer, practice of skills (conversation management) and self-awareness, were implemented.

Treatment options that go beyond the general medical consultation and specific interventions for pathologies such as somatoform disorders, chronic pain disorder, depression, anxiety and eating disorders could only be taught in rudimentary form due to the limited time available. Here, the continuing education in psychotherapy is the next step. In our course offerings, psychosomatic primary care and advanced training in psychotherapy are therefore closely interlinked (Fritzsche 2008, Fritzsche et al. 2010).

42.2.3 Results on medical interview behavior

In 1994, a nationwide demonstration project "Quality Assurance in Primary Psychosomatic Care" funded by the Federal Ministry of Health started. It was part of a model program to promote medical quality assurance in outpatient care (Fritzsche et al. 1996, 1999, 2000).

Methods

In the first phase of the project, 191 physicians in private practice, predominantly general practitioners and internists, documented a total of 1341 treatment episodes of patients in whom, according to the physician's assessment, psychological or psychosocial problems and conflicts played a decisive role in the clinical picture (Sandholzer et al. 1999).

Results

In terms of psychosocial interventions, therapeutic conversation by the primary care physician represented the largest proportion of interventions. Women and men did not differ in terms of the talk therapy interventions performed. However, the indication depended significantly on the type of psychosocial distress: Patients diagnosed with anxiety, depressive symptoms, distress from life events, and sleep disorders were more likely to receive talk therapy. Patients who exhibited distress from physical ailments were more likely to receive other medical treatment interventions, such as medication. In terms of treatment outcomes, the following picture emerged: patients with talk therapy interventions improved more in their symptoms since diagnosis. They developed a psychosomatic understanding of illness in a greater percentage than the group of patients without talk therapy. Both from the physician's and the patient's side, the understanding between physician and patient, the success of the treatment and the satisfaction with the treatment were assessed significantly higher in patients who received talk therapy interventions than those without these measures.

Conclusions

Conversation offers were accepted equally by both genders. Women and men also benefited to the same extent from the conversation measures. Hence, physicians should ask their male patients more directly about psychosocial stress, since men tend to deny it or consider it insignificant.

Patients with conversational measures showed significantly higher scores on outcome variables than patients without these measures and

were more likely to develop a psychosomatic understanding of illness than patients who received mainly somatic measures. However, it was also found that patients for whom physical complaints, especially pain, were the main focus and who did not develop a psychosomatic understanding of illness were rarely offered a therapeutic conversation, even though psychosocial stress was known. Switching to medication, physical therapy or alternative treatment methods remained unsatisfactory for these patients in terms of treatment success. As in outpatient psychotherapy, patients with psychological symptoms are apparently preferred in psychosomatic primary care.

A major result of the collaborative study was the development of targeted conversation interventions in the context of general practitioners practice for patients with somatoform disorders. These interventions aim at the development of a psychosomatic understanding of illness, which, as the study results show, is crucial for the success of treatment (Fritzsche, Larisch 2003, Larisch et al. 2004, Fritzsche et al. 2010).

42.2.4 Psychosomatic Primary Care

In May 1992, the 95th German Medical Congress included parts of psychosomatic primary care in their given example for the ideal structure of further trainings for all clinical areas. All physicians should be able to demonstrate in-depth knowledge, experience and skills in psychosomatic primary care. On March 18, 1988, the board of the Baden-Württemberg Medical Association passed the resolution for the first time, which was later reaffirmed, that the in-depth knowledge, experience and skills should be acquired as part of a 40-hour further education program. The contents of this so-called "psychosomatic basic knowledge" include 8 hours of theory, 12 hours of teaching and practicing medical conversation, 10 double-hours of Balint group and the documentation of treatment cases.

So far, there are no binding statements about the goals of psychosomatic primary care in hospitals. However, we assume that, similar to the primarily somatic physician, the primary tasks for the hospital physician are also the early recognition of psychosocial problems and conflicts and a limited offer of clarifying, relieving and supporting conversations with the patient.

Since September 2000, 40-hour courses have been held as part of the further training for medical specialists (Fritzsche, Schweickhardt

2003). In a live conversation with a patient, the physician's conversation techniques are demonstrated ("learning from the model"), and problems of recognition and treatment in the physician-patient relationship are discussed. The exercises in conversation management take place in small groups on the topics of patient-centered conversation management, informational and explanatory conversation before operations and diagnostic interventions, the aggressive patient, breaking bad news and involving relatives. The day concludes with the Balint group.

So far, there exist only a few empirical studies on biopsychosocial stress, treatment measures and treatment outcomes from the point of view of physicians in the context of basic psychosomatic care in hospitals (Gosda 2005) and on the effects of psychosomatic training for clinicians (Söllner et al. 2000, 2007).

Methods

Following the course, all physicians who participated in the courses between 2003 and 2010 completed a basic documentation of the patients they cared for in the hospital (Sandholzer et al. 1999). The same baseline documentation was used as for the Federal Ministry of Health's collaborative project on quality assurance in primary psychosomatic care (Sandholzer et al. 1998) and was slightly modified for the hospital physicians.

Results related to the communicative competence of physicians

367 physicians documented a total of 2028 treatment cases. The physicians were mainly distributed among the specialties of internal medicine, surgery, anesthesia, gynecology, pediatrics, general medicine, orthopedics, neurology, ENT, and dermatology. The most common therapeutic interventions were consultation (68%), diagnostic (45%), and therapeutic interview (44%). Similar to the primary care outcomes, patients who received psychodiagnostic and therapeutic conversations had significantly better treatment outcomes in terms of mutual understanding, treatment success, and treatment satisfaction than patients without these conversations.

In 46% of patients, physicians were unable to provide information on the psychosocial history. This indicates a time problem on the one

hand, but also a lack of practice in integrating psychosocial topics into the initial interview on the other hand (Fritzsche et al. 2012).

Conclusions

The small differences in documented treatment cases between surgical and non-surgical specialties encourage that interdisciplinary courses should be offered in the future. Subgroups can address specific topics for surgeons, e.g., educational interview before surgical procedures, or for pediatricians, the involvement of parents in psychosomatic problems in childhood. Courses on psychosomatic primary care should become an integrative mandatory part of medical specialists further training in all clinical specialties.

42.3 Future goals in Psychosomatic Primary Care

Seven important quality objectives in psychosomatic primary care were named by the project group "Quality assurance in psychosomatic primary care" (Autorengruppe Psychosomatische Grundversorgung 2001, Fritzsche et al. 2000):

1. The recognition of psychosocial findings
2. The development of a psychosocial understanding of the disease
3. The treatment satisfaction of the physician/patient
4. The physician-patient relationship
5. The avoidance of chronification
6. The targeted treatment
7. The exchange between colleagues

In a systematic literature review (Fritzsche et al. 2006), a total of 9 controlled studies were found in which the general practitioners themself carried out the psychosocial interventions. In most studies, the psychosocial interventions for general practitioners were found to be more effective than routine care or placebo treatment and as effective as psychopharmacological treatment. Overall, the clinical effects achieved were mostly small and short-lived. Studies using specific therapeutic approaches for specific disorders (e.g., specific therapeutic manuals for

somatizing patients) showed the best efficacy. Two fundamental problems emerge in achieving stronger effects through psychosocial intervention by the primary care physician: limited time and other competing tasks of the primary care physician (e.g., concurrent treatment of organic diseases, medical emergencies). Future goals of psychosomatic primary care can be derived from these findings:

- The conceptual development of brief structured psychosocial interventions for the most common psychosomatic disorders that can be applied in the context of family practice when time is often limited and organizational structures tend to be hostile to psychotherapy
- To identify core components common to all psychotherapeutic interventions, such as the quality of the therapeutic relationship, the development of an understanding of the patient's problem, and helping the patient change behavioral and thinking patterns and manage distressing emotions. The main differences between primary care physicians and specialist psychotherapists would be the goals of the interventions (e.g., psychoeducation, short-term emotional relief, motivation for psychotherapy), the limited time frame, and the professionalism with which these interventions are carried out

The model of Reflected Casuistry (Geigges 2003) is suitable for concrete case work, e.g. in quality circles in psychosomatic primary care. Reflected casuistry is understood as the application of the meta-model of integrated psychosomatic medicine in medical practice. Theory and practice should influence each other, so that the theoretical model remains a "learning model". Central questions in the sense of a reflected casuistry are:

- Is there a fit between the physician's treatment model and the patient's disease in terms of system levels? (Is there, for example, no fit between a primarily psychotherapeutic treatment model of the physician and an acute myocardial infarction of his patient?
- Which model does the practitioner use to describe the patient's problems?
- What other problem descriptions are possible?
- Which ones are appropriate to the disease (pragmatic or communicative reality constructions)?

- What is the fit between patient and practitioner in terms of therapeutic goals and associated tasks (treatment mandate)?
- Is there a fit in the view of the disease between patient and practitioner? Is there a successful communicative coordination?
- Is there a fit between the therapeutic relationship sought by the patient or offered by the physician?
- Is there a fit between the treating physician and other "treatment providers" (e.g., ward team, primary care physician, family, social services) toward the patient (communicative team integration or additive coexistence?)
- Are there competing missions and treatment strategies?

42.4 Further information

The techniques of active listening, especially letting patients finish speaking at the beginning of a medical consultation, have proven their worth. This was also empirically proven in a study at the Basel Cantonal Hospital: the average speaking time of patients was 92 seconds. 78% of patients completed their reports within two minutes. In the study, physicians were asked not to interrupt their patients. Only 7 of 335 patients spoke for more than 5 minutes. In the opinion of the attending physician, the information given was nevertheless so relevant that it was worthwhile not to interrupt the patient (Langewitz et al. 2002). What is effective and essential in the physician-patient relationship are not the interview techniques used, but the personality of the physician and the way the relationship is formed. In a literature review in the „Lancet“, Di Blasi et al. (2001) examined the various aspects of the placebo effect. They showed how nonspecific or so-called contextual factors, for example, the physician-patient relationship, influenced the specific therapeutic procedure chosen. One result was that physicians who combined emotional empathy with confident demeanor and comprehensible information had better therapy outcomes compared to more uninvolved, impersonal, formal, and vague colleagues.

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Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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