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CORR Insights®: Patients With Greater Symptom Intensity and More Disability are More Likely to be Surprised by a Hand Surgeon's Advice

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Where Are We Now?

Clear and concise communication between the physician and the patient is an important part of a well-functioning

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physician-patient relationship. Good physicians continue to develop the ability to communicate in ways that are technically precise, yet still compassionate and empathic. But for many reasons, sometimes information is lost in translation. Much is being done to understand this gap in knowledge and its causes [1, 3, 4]. We now have validated psychological tools that allow us to examine perceptions, behaviors, and coping strategies. The current tools, such as the DASH, Patient Health Questionnaire-2, Pain Self-Efficacy Questionnaire-2, Minnesota Multiphasic Personality Inventory, Short Health Anxiety Inventory-5, Trauma Symptom Checklist-40 inventories are excellent [2]. These are validated tests that now give us a broader understanding of outcomes and typical values in certain disease processes. With these tools, we can

develop a deeper understanding of our own communication and teaching skills. Using them, healthcare providers can better recognize how a particular patient will absorb technical information, and physicians can anticipate and react accordingly. But what causes these gaps in communication? Is it the educational level? Psychological factors? The environment in which the knowledge is transmitted or cultural factors from both parties that lends itself to poor communication? The existence of this communication gap requires careful evaluation. The study by Strooker and colleagues begins to define those parameters.

Where Do We Need To Go?

Healthcare professionals are now beginning to approach this communication gap in several ways. They are beginning to study outcomes in patients with issues ranging from secondary gain, pain perception correlated to the actual disease process in spine

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research, the mental health aspects of a person's life and its affect on their physical health, educational level of the patient, cultural background and the effects of these psychological environments of the patient's on the outcomes [3, 6]. A codification of personality traits, perceptions, and responses to certain kinds of stresses are being developed for specific interactions and disease processes. Our response to patients will be determined and be part of the treatment as we begin to recognize the importance of different psychological factors and predictors that cause patients to respond in particular ways to stressors in the clinical setting. We need more assessment and validation in studies with larger patient cohorts. Baseline measurements in homogeneous, and culturally diverse populations need to be defined. Once baseline information has been gathered, we can begin to test interventions and their modification based on the culture, education, and personality types of a population. Studies are exploring these topics across many disease processes, as well as by evaluating other elements of the problem, including coping abilities [7]. Strooker and colleagues have identified a group of patients who are surprised by the physician's solution to their problem, these patients have more severe symptoms and greater levels of disability. Studies like this

that define the at-risk populations are important to our improved understanding of this important problem, and we need more studies like this.

How Do We Get There?

We need further studies that examine and validate psychological responses to information, clinical stressors, and our interventions.

Validating tools, DASH, Minnesota Multiphasic Personality Inventory, Myers-Briggs, and standardizing short forms for everyday clinical use would be extremely valuable for the practicing physician, as well as for the researcher looking to understand both patient and physician behavior. Surveys that examine the response of clinical personnel to the coping strategies of patients would better define the dynamics of the interactions between caregivers and patients. We already know a great deal about the psychology of teams engaged in purposeful behavior [5, 8] and this work should be applied to the health care setting except that it is between a patient, the objective being their health, and the team providing the solutions.

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