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ODESA NATIONAL MEDICAL UNIVERSITY

PROFESSIONAL COMMUNICATION. PROTOCOLS OF “DOCTOR-PATIENT” COMMUNICATION

A Study Guide

Edited by
professor Valeriia Marichereda

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The study guide outlines the fundamental principles and methods of doctor-patient communication in various situations.
For higher education students, interns, and doctors of all specialties.

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ABBREVIATIONS

ARVI — Acute Respiratory Viral Infection

ICD-10 — International Classification of Diseases, 10th Revision

MOCBT — Mindfulness-Oriented Cognitive-Behavioral Therapy

BUSTER — BE prepared, USE nonjudgmental listening, SIX second rule, TELL me more, EMPATHIZE and validate, RESPOND with a wish statement. This protocol is used during difficult emotional conversations with the patient and their relatives

CLASS — CONTEXT, LISTENING skills, ACKNOWLEDGE, STRATEGY, SUMMARY. Basic doctor-patient communication protocol.

CONES — CONTEXT, OPENING short, NARRATIVE approach, EMOTIONS, STRATEGY.
This protocol is used in cases of medical errors, deterioration of the patient's condition, and conversations with the relatives of the deceased

DSM-5 — Diagnostic and Statistical Manual of Mental Disorders, 5th Edition

EVE — EXPLORE the emotion, VALIDATE the emotion, EMPATHIC response.
This protocol is used when the patient and their relatives exhibit strong emotions, to provide support and stabilize their condition

ISBAR — IDENTIFICATION, SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION.
This protocol is used for the transfer of information between healthcare professionals to ensure a structured and clear exchange of data about the patient's condition, for example, when transferring a patient to another medical facility

SBAR — SITUATION, BACKGROUND, ASSESSMENT, RECOMMENDATION.
This protocol is used by healthcare professionals to convey patient information, particularly during handoffs or transfers of responsibility, such as during shift changes in a department

SMART — SPECIFIC, MEASURABLE, ACHIEVABLE, RESOURCED, TIMED).
This is a rule for goal setting

SPIKES — SETTING up the interview, Assessing the Patient's PERCEPTION, obtaining the Patient's INVITATION, Giving KNOWLEDGE and Information to the Patient, Addressing the Patient's EMOTIONS with Empathic Responses, STRATEGY and SUMMARY.
This protocol is used for delivering bad news

TIMER — THINK Through the Encounter (ahead of time), INTRODUCE Issues, MANAGE the Discussion, ESTABLISH a Plan and Expectations, REVISIT and Give Feedback.
This protocol is used for effective interaction in the workplace regarding important issues of discipline and relationships

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We express our sincere gratitude to Hanna Marchuk for allowing us to make her life story with a serious disease the basis of this study guide.

We extend special thanks to Maria Dukova, Anastasia Sadova, Daria Burlak, and the 6th-year students of the Odesa National Medical University for their active participation in creating the video comics.

HOW TO USE THIS STUDY GUIDE?

Dear readers! This study guide is unique. Considering that not all nuances of non-verbal communication, tone of voice, and intonation can be clearly conveyed in text, and these are the very elements that reflect the “art of communication”, we have decided to supplement the text with additional illustrations and video clips. QR codes are provided for all video materials, each linking to a specific video clip for each situation.

We hope that mastering communication skills with the help of our study guide will be an enjoyable adventure for you.

INTRODUCTION

Medical care is interpersonal by definition — one person seeks help from another. Without effective communication, medical care is at best ineffective, at worst dangerous.

ANTHONY L. SUCHMAN,
MD University of Rochester (USA)

The inspiration for writing this study guide came from the story of Hanna, the sister of our colleague. We are sincerely grateful to Hanna for allowing us to publish her story as a valuable experience for many professionals. Although, for clarity, we have made some changes to the behavior and statements of the doctors, and even added a few details, the overall story is described truthfully.

Hanna is a young, beautiful, and vivacious 38-year-old woman whose company was very pleasant. We met during the celebration of our colleague’s birthday. There was no hint of the disease Hanna was suffering from, which we learned about a little later. The only thing that set her apart from the other guests at the party was that she did not drink alcohol at all. When asked the usual question in such situations about expecting a child, she simply responded with a smile. Later, during our conversation, she shared her story, which became the basis of this book.

Undoubtedly, the psychological state and personal characteristics of the patient play a significant role in the course of the disease, as stated in many articles and monographs. However, Hanna’s story made us realize that everything is not always so clear-cut, and if she had faced another doctor...

Therefore, we decided to explore what makes a patient consider a doctor “good” or “not so good”, and how the behavior of a doctor, or even a single phrase in a particular situation, can have a crucial impact on the patient’s entire future.

Our goal is to uncover important secrets of the medical profession that most professionals do not pay enough attention to, but which should form the backbone of the doctor-patient relationship and the foundation of successful treatment.

We can confidently say that the art of professional communication with the patient is as essential for a doctor as professional knowledge, clinical thinking, and practical skills, because unexpressed emotions of the patient can render all the doctor's efforts absolutely futile. In many cases, effective communication skills are indispensable. We will examine key aspects of communication without which quality patient care is simply impossible. You will also understand that the effectiveness of the doctor's behavior is crucial for the course of the disease, and ineffective behavior not only negates the results of even the most qualified consultation but also leads to unexpected negative consequences.

We will introduce you to protocols for doctor behavior that significantly enhance the quality of patient care and can improve the patient's well-being (even when dealing with incurable diseases). You will become familiar with the basic doctor-patient communication protocol CLASS, the interaction algorithm CONES, which helps in cases of medical errors, patient deterioration, communication with the patient's relatives, and death notifications; the BUSTER protocol, which enables successful resolution of difficult emotional situations (such as dealing with an unsatisfied patient); and the most complex protocol, SPIKES, which is the "gold standard" worldwide for communicating bad news to a patient or their representative and requires all the communication skills of the doctor.

We will also provide several tools for the psychological self-protection of the doctor, who can also suffer psychological trauma after interacting with certain types of patients. In the appendices, you can find QR codes linking to video reviews of these protocols.

Through specific examples, we will reveal and demonstrate the entire doctor-patient relationship system. Human behavior is most influenced by other people. Here, we will discuss the guidelines you can rely on while building a therapeutic alliance. Every doctor wants their efforts to be effective: for the patient to follow recommendations and recover, for the treatment to be helpful, and for them to feel like an effective professional. Here, you will find examples of how ineffective communication by the doctor can hinder patient care, lead to exhausting conversations and even conflicts, and result in treatment refusal.

For a patient, visiting a doctor is not just about getting a prescription or undergoing surgery. It is, above all, about receiving compassion, gaining confidence in recovery or maintaining quality of life, as well as experiencing a kind look and attentive listening. The doctor's office should be a place where the patient can receive support, talk openly about prognoses, complications, and side effects of treatments.

The doctor faces a very challenging task: to demonstrate professional skill and simultaneously create an atmosphere of trust and cooperation with the patient in a short period of time. A quiet, safe space and establishing and maintaining contact with the patient are essential for creating this atmosphere. While gathering the necessary information about the disease manifestations, clarifying what the patient thinks about it—their expectations or fears—the doctor must help the patient approach their health more thoughtfully and follow all recommendations. Step by step, the doctor must consider complex situations, paying attention to body language (the so-called non-verbal cues), thereby recognizing signs of anxiety or aggression in the patient.

We will help you understand and learn to build all these complex relationships between the doctor and the patient that arise during consultations. We will demonstrate the main psychological tools available to doctors: verbal and non-verbal communication skills, and active listening skills. Additionally, we will focus on personal feelings and reactions that sometimes interfere with the dialogue and change behavior. These factors will not go unnoticed, and we will examine situations where they can radically alter the course, dynamics, and outcomes of the consultation. This is why it is important to learn to be aware of and control your emotions, and to stabilize a difficult psychological state. The ability of a doctor to use his own personality as a tool — this and many other things are covered in this manual.

In addition to Hanna's story and comments on the behavior of all participants in this story, we consider it appropriate to discuss the emergence and development of concepts about the psychology of communication from ancient times, which, in our opinion, will not only increase the fundamental nature and significance of this manual but also demonstrate the real place of the art of communication in our lives.

CHAPTER 1

A BRIEF HISTORY OF COMMUNICATION METHODS

Humans began attempting to communicate with each other from the moment they realized they were separate entities. Therefore, the history of communication methods began with the appearance of the first human and encompasses millennia of the development of ways to transmit information between people: from primitive tribal signs to modern digital technologies. The entire history demonstrates how humanity has tried to make communication more efficient and accessible. One of the most interesting facts is that no basic type of communication that emerged has disappeared over time: it may have transformed but has not vanished and is still actively used today. We will not delve too deeply into the details of the development of communication tools and methods—let historians do that; we will only outline the key stages.

Oral transmission of information. Initially, people transmitted information using gestures, poses, facial expressions, and the intonation of specific sounds, much like animals. Therefore, we do not consider this method the first in human communication. The true human method of communication became sets of sounds that were consciously composed, had clear meanings, and later came to be called "words". After the appearance of words, information was orally transmitted from one person to another. Oral stories, legends, and knowledge were passed down from generation to generation.

When people realized that oral transmission of information could distort it significantly, they began trying to somehow fix the core meaning. It was then that they had to invent written symbols. With the development of literacy, people created symbols and scripts to fix information. Initially, these were pictograms, then hieroglyphs, and later alphabets. The oldest examples of writing are considered to be inscriptions on animal bones and tortoise shells in the Neolithic settlement in the grottoes of the Stone Tomb in the Henan province

of China, which are approximately 8,000 years old (according to Sumerologist A. G. Kifishin, they date back to the VII–III millennia BC).

When humanity understood how information could be fixed, a new question arose: on what medium could it be best placed for long-term storage and easy transmission? In response to this challenge, papyrus and parchment emerged as the best inventions. The first versions of these mediums were developed in Ancient Egypt and Mesopotamia, allowing information to be stored and transmitted over long distances.

The next step in the development of communication can be considered the invention of ***printing***. The invention of the printing press by Gutenberg in the 15th century revolutionized the exchange and transmission of information. Books became more accessible, greatly influencing the speed of knowledge dissemination.

Once information was fixed on a convenient medium, a new challenge arose for humanity: how to transmit this information more conveniently to one another, especially if you didn't want it to get lost along the way. Thus, the need for ***mail*** arose, opening up the next stage in the history of communications. With the development of communication routes, including improved postal systems, people could exchange letters and messages over great distances.

In the 19th century, a new convenient and fast method of information transmission was invented — the ***telegraph***. However, humanity did not stop at the development of only written communication. Most people preferred oral communication, but long distances posed a challenge. Therefore, alongside the telegraph, the ***telephone*** had to be invented. The telegraph and telephone enabled messages to be transmitted using electrical signals, representing an important step in the development of instant communication over long distances.

The next revolutionary step in the transmission and preservation of information was made by the inventors of ***radio and television***. The development of radio and television in the 20th century allowed sound and visual informational messages to be transmitted to a mass audience.

But even this seemed insufficient to humanity, so in the second half of the 20th century, ***personal computers and the Internet*** were invented. With their appearance, the communication paradigm itself changed. Email, social networks, websites, and other digital tools made communication fast, global, and accessible to all.

When a full understanding of the Internet's capabilities was reached and technologies emerged that significantly reduced the size of components for computers and other devices, the era of ***mobile, wireless, and remote technologies began.*** The development of mobile phones and smartphones allowed people to stay connected practically all the time and everywhere, leading to new forms of communication such as text messaging, messaging apps, and so on.

However, the rapid pace of technological development, the thrill of discovery, the growing need to transmit ever-increasing volumes of information, and the desire to enter uncharted territories led to the emergence and active development of ***artificial intelligence, virtual reality, and augmented reality***. These advancements may contribute to the emergence of new interactive communication methods, which are still in the experimental stage.

Undoubtedly, the development of communication methods has significantly impacted all fields of activity, and medicine is no exception. The history of professional medical communication marches alongside the development of human history and communication methods. It encompasses many stages and changes associated with the growth of medical knowledge, technologies, and societal changes. However, the goal of this manual is to teach modern methods of communication between doctors and patients, so in this section, we will only provide some key points and stages, and those interested in this issue can find more in-depth information independently.

The means and methods of communication between doctors and patients have always corresponded to the peculiarities of human life in different historical epochs of human development.

Antiquity and the Middle Ages. In ancient times, medical knowledge was mainly transmitted orally from master to disciple. Doctors learned practical skills without formal education. In ancient civilizations such as Ancient Greece and the Roman Empire, the interaction between doctors and patients mainly took the form of conversation. Hippocrates and other physicians learned to observe symptoms and listen to patients' complaints. In the Middle Ages, medicine was influenced by religious beliefs, and doctors widely used prayers and amulets. Communication was significantly limited. Medical records played an important role in communication between doctors and patients during this time, documenting the results of observations and treatment.

The Renaissance. During this period, there was a significant rise in the development of medical science, particularly in anatomy and physiology. The emergence of the first scientific journals, where doctors published their researches and observations, marked a significant increase in the role of the scientific method in medicine during the Renaissance. The first medical faculties appeared in universities. Doctors began to rely more on observation, research, and laboratory experiments. Communication between doctors and patients became more systematic.

18th–19th centuries. The growth of scientific knowledge and the development of medical universities led to greater structuring and formalization of medical education. Doctors began to use scientific research methods, and communication on medical topics became more scientific and well-founded. However, communication with patients still remained formal and distant.

20th century. Technological advancements expanded communication capabilities. The invention of the telephone and radio, and later television, allowed doctors to disseminate medical advice and information to large audiences. In the second half of the last century, after World War II, the importance of communication between doctors and patients was recognized and significantly increased. The development of medical ethics contributed to more open and trusting communication.

Our time. The advent of the Internet revolutionized medical communication. Doctors began to write blogs, create video tutorials, and publish scientific articles in online journals. Specialized medical forums emerged, where professionals could discuss clinical cases and exchange experiences. Today, medical communication occurs on multiple levels. Doctors use social media for patient education and communication with colleagues. Telemedicine enables remote consultations, and artificial intelligence helps analyze medical data. Thus, in the modern world, communication between doctors and patients has become a key aspect of both clinical medicine and diagnosis. Nowadays, doctors worldwide are trained not only to treat diseases but also to listen to and understand patients, explain diagnoses and treatment options, and consider their psychotype, preferences, and values.

Thus, communication between medical professionals and patients has undergone significant changes throughout human history. Of course,

the medical process has always included a psychological component of interaction between the doctor and the patient. However, in the past, this was more based on the authority of the doctor and professional norms than on the study of psychological aspects of communication. Only in the mid-20th century did active work begin on the development of psychological approaches to communication with patients. A pioneer of the psychological approach in professional medical communication can be considered the physician Carl Rogers, who developed the approach of "client-centered therapy", focused on the importance of empathy, listening, and understanding the patient.

Simultaneously with the development of client-centered therapy and the spread of understanding the relationship between the psychological and physical state of a person in the mid-20th century, psychosomatic medicine emerged. This led to a greater emphasis on the importance of the psychological component in treatment and communication with patients.

Over time, research confirming the impact of communication quality on treatment outcomes emerged. This was called "communication effectiveness". Doctors began to realize that well-established and trusting communication can improve patient recovery.

From the 1980s, an active campaign to increase patient awareness of their rights and opportunities began. This gave rise to the concept of "patient informedness". This further emphasized the importance of open and understandable communication with doctors.

Today, psychological communication methods have become more complex and diverse. Interactive communication, the use of active listening skills, demonstrating empathy, and support are necessary attributes of doctor-patient interaction.

Modern medical education programs in universities pay more attention to teaching future doctors communication skills. Doctors are trained to communicate effectively, explain complex medical concepts clearly, and support patients in difficult situations.

Modern technologies, such as telemedicine and electronic medical records, have also influenced the way doctors communicate with patients. This requires adaptation of communication strategies to virtual environments.

All these stages together have contributed to the evolution of communication between doctor and patient from a traditional medical approach to a more psychologically grounded one.

How to preserve the essential healing power of effective communication in our days, in the era of telemedicine and electronic technologies, when communication between doctor and patient requires special attention to detail? How to ensure quality medical care and maintain trust between doctor and patient? To achieve this, it is necessary first of all to remember the basic factors that ensure communication effectiveness.

Confidentiality and data security. First and foremost, the patient must be confident that the doctor considers confidentiality and data security during electronic consultations crucial. Therefore, using reliably protected platforms for data exchange and complying with personal information protection requirements should be priorities for the doctor and ensure patient confidence in safety.

Clarity and accessibility. Use simple and understandable language, avoiding medical terms that the patient may not understand. Explain medical terms if necessary. Ensure patient access to information using online portals where they can view their medical records and test results.

Effective scheduling. Provide patients with the opportunity to schedule consultations online by appointment. This helps avoid busyness and ensures productive time for each patient.

Visual contact. If patient consultation can be conducted remotely, try to do so using video communication. Using video conferencing tools allows the doctor and patient to see each other, which helps establish a personal connection. Faces can convey a lot of information that cannot always be conveyed in words.

Active listening. Remember the importance of active listening. Give the patient the opportunity to share their complaints and ask questions, make sure you understand them correctly, clarify information if necessary.

Maintaining contact. After the consultation, the patient should always receive a brief summary of the discussion from the doctor in the form of a diagnosis, action plan, and recommendations. This helps avoid misunderstandings and ensures the adequacy of treatment.

Taking into account the individual characteristics of the patient is crucial. Consider cultural, linguistic, and physical differences among patients. Maintain cultural sensitivity and strive to ensure access to telemedicine even for those who may have limited access to technology.

Questioning and feedback. Encourage patients to ask questions and provide feedback on their telemedicine experience. This will help you improve the communication process.

Education and information. Provide patients with reliable medical information and resources for self-education regarding their condition and treatment.

Thus, communication in the era of telemedicine should be effective, confidential, and compassionate, taking into account all the patient's characteristics and utilizing available technologies for remote medical assistance.

CHAPTER 2

PROTOCOLS OF PROFESSIONAL MEDICAL COMMUNICATION

Professional communication protocols are standardized methods and rules of communication used in various professional spheres to provide efficiency, clarity, and understanding of interactions between different parties. They help reduce misunderstandings, improve collaboration, and facilitate task execution. These protocols may regulate interactions between a medical facility's manager and other staff members, among staff within the medical facility, with staff from another medical facility, or between a medical professional and a patient or patient's relatives.

The main protocols for standard communication among healthcare professionals, recognized as "gold standards" in most developed countries, are SBAR and ISBAR.

SBAR: Situation, Background, Assessment, Recommendations.

This abbreviation is used by healthcare professionals to convey information about a patient, especially during shifts or handovers of responsibility.

This abbreviation is used in medical settings for structured information transfer between healthcare professionals, particularly during handovers of responsibility or when conveying important patient information. The protocol helps ensure clarity, consolidation, and effectiveness of communication in situations where it is important to quickly and accurately convey information. It stands for:

Situation: The current situation and context where the interaction is taking place, which may include patient identification and what is happening at the moment.

Background: The patient's history, their condition up to this point, past health issues, and other important medical data necessary for understanding the current situation.

Assessment: medical assessment or diagnosis of the patient, may include any indicators of the patient's condition, test results, or laboratory analyses.

Recommendation: recommendations and actions proposed for the patient, may include a treatment plan, specific measures to be taken, and those responsible for them.

This protocol is designed to provide a structured approach to the transmission of medical information, especially in conditions of increased urgency or when handing over responsibilities among medical staff. It helps ensure consistency and completeness of the information conveyed, reducing the risk of misunderstandings or omissions in medical details.

ISBAR: Identification, Situation, Background, Assessment, Recommendations. Used to facilitate structured information exchange between healthcare professionals.

This is another medical communication protocol used for transmitting information between healthcare professionals to ensure structured and clear data exchange regarding the patient's condition. This protocol is based on five components and aims to facilitate effective transmission of medical information. It means:

Identification: identification of oneself and the patient, including full name and other identification data confirming that you are dealing with the actual patient.

Situation: describes the current status of the patient, such as why you are contacting, what happened, what questions or issues arose.

Background: provides important patient data, their condition up to this point, past issues, diagnoses, and recommendations.

Assessment: evaluates the patient's current condition based on your observations and objective data..

Recommendation: indicates specific actions you recommend or propose for the patient: treatment plan, recommendations for further investigations or examinations, etc.

This protocol promotes the efficiency of medical communication by helping to standardize the transmission of information and ensuring completeness and clarity of exchange among healthcare professionals. This is particularly important in situations where it is necessary to quickly convey important patient data or change responsibility for care.

TIMER: Prepare in advance for the conversation. Inform about the issues, Manage the discussion, Establish a plan and articulate expectations, Review the matter and provide feedback.

TIMER is a quite widespread business communication protocol in the medical field of European countries and the USA. It is used for effective interaction within a work team regarding important matters of discipline and relationships. The protocol consists of several steps, the initials of which form its name.

Think Through the Encounter (ahead of time): Consider the questions you would like to discuss at the meeting. Ensure you have all the necessary information for the conversation. Align your position with the management and secure support. Rehearse the words you would like to say to prevent emotions from interfering, and stay on topic. Establish time frames for yourself.

Introduce Issues: Create a comfortable environment (prepare comfortable chairs, ensure the absence of distractions), clarify the colleagues' readiness for the conversation. Maintain nonverbal contact throughout the meeting (body posture, facial expressions, tone, speech pace, eye contact, nods). Clearly state the problem to avoid defensive reactions — we will discuss this thoroughly in the main part of the training manual. An example of starting the conversation could be "I would like to discuss an important topic with you. Do you mind? I am concerned about your interaction with a colleague..."

Manage the Discussion: Focus on what the interlocutor is saying and try to remain calm. This step requires adherence to certain rules:

— Be objective.

— Use terms like "please elaborate" to clarify information.

— Let your colleague know that you empathize with them, but clarify why the situation elicited such feelings and reactions from them (for example, "You say you feel like you've been treated unfairly. Can you tell me more about what you mean?").

— Apply the 6-second rule for emotional escalation.

— Use emotional validation, "I hear the anger in your voice; you're talking about unacceptable behavior from a colleague..." or "I see, this caught you off guard, it's difficult for you to hear my words".

— Express wishes, "I would like to change this", "I wouldn't want to revisit this conversation".

Establish a Plan and Expectations: Develop a joint plan that will be effective in solving the problem. Be sure to involve your colleague (for example, with a phrase like, "What do you think we can do in this situation?"), clearly articulate your expectations (for example, "It's important that we reach this decision together", "What steps can you take to avoid similar situations? Tell me specifically").

Revisit and Give Feedback: Support this with approval phrases, for example, "I appreciate your efforts." If nothing has changed after the conversation, at this stage, adhere to the following rules:

— Identify the problem, "I see that you are not coming to work on time".

— Investigate the problem, "I want to clarify what is preventing you from fulfilling our agreement?".

— Reiterate the need for improvement, "This is important for our team; let's discuss again how we can rectify the situation"

— Clearly state the consequences of not following the agreements from the previous conversation, "I'm trying to avoid punishment. You're a talented colleague, but there are conditions for continuing our work together".

SMART: Specific, Measurable, Achievable, Resourced, Timed.

The goals of the conversation are fully disclosed at this stage. To ensure they are adequate and acceptable to your interlocutor, we recommend using the SMART goal-setting rule:

Specific: Clearly defined and focused.

Measureable: Quantifiable and trackable.

Achievable: Realistic and attainable.

Resourced: Supported by the necessary resources.

Timed: Bound by a specific timeframe.

After agreeing on the formulated goals, plan, and expectations, it is necessary to summarize everything (for example, with a phrase like "So, here's what we've decided...").

Finally, it is important to set the timing for the next meeting to review the conversation's outcomes.

Possessing these protocols (rules) always helps in accurately allocating roles, avoiding misunderstandings, and ensuring a structured and effective communication process in various professional spheres.

In addition to professional communication within a team, it is extremely important for a doctor to have the ability to communicate effectively with their patients. Most protocols will be discussed in the main part of this guide, and in this section, we will provide an example of one of the most useful communication protocols with patients — the EVE protocol.

EVE: Explore Emotions, Validate Emotions, Empathic Response.

This protocol is used when strong emotions are expressed to support and stabilize the patient and their relatives. According to this protocol, the doctor should briefly and clearly express their emotions to facilitate the patient's expression of fear, hopelessness, so that these feelings do not block the patient. This strengthens mutual trust. The main components of this protocol are as follows:

Explore the emotion: Investigate and identify the emotions that the patient and their family members are feeling at the moment. React to obvious manifestations. Observe, perceive the object, i.e., see, hear, meet with clarity, explicitness.

"I hear your sad voice...", "I see that you frown when talking about your health condition."

Validate the emotion: Let the patient know that their emotions are appropriate, you perceive and understand them, that the fear of disease, complications, an incurable diagnosis can cause

strong emotions, so this cannot evoke condemnation. This will strengthen trust.

"When you say that the treatment, unfortunately, does not improve your father's condition, it is understandable that it saddens you."

Empathic response: Express your emotions to show that you care about the pain, suffering; ready to support the patient, be there, ready to consider possible treatment options.

"I will do everything in my power, we will find medications that will relieve your pain."

Thus, the psychology of communication studies how people interact, exchange information, and influence each other through language, nonverbal signals, and other communication means. The basic concepts and principles of communication psychology help understand how interaction between people occurs and how it can be made more effective and satisfying for all parties involved.

In addition to medical communication protocols, you may encounter numerous situations where knowledge of other interaction rules is required. Here are some examples of professional communication protocols:

1. Business Protocols:
   - Email: clear and concise messages, use of subject lines, obligatory greetings and farewells.
   - Presentations: structured format, clear highlighting of key points, use of images and graphics to reinforce information.
2. Educational Protocols:
   - Formulating Questions: using open-ended questions to stimulate discussion and reflection among learners.
   - Active Listening: maintaining eye contact, supporting responses, and expressing interest during discussions.
   - Task Formulation: clear and understandable task formulation for learners.
3. Information Technology Protocols:
   - Error Reporting: structured report of an error or issue, including a description of the situation, impact, and recommendations for correction.
   - Scrum Meetings: short daily meetings to report completed work and plans for the day to ensure coordination within the team.

4. Social Sciences Protocols:
   - Interviews: using a structured list of questions to obtain information from respondents.
   - Focus Groups: structured group discussions on a specific topic to reflect different viewpoints.
5. Legal Protocols:
   - Documentation: structured formatting of contracts, statements, and documents that comply with legal standards.
   - Violation Reports: structured report or notification of a violation, including evidence and facts.

2.1. The Calgary–Cambridge Basic Model of Medical Consultation

If you carefully read this section, you probably have a question, "How can all these communication protocols and rules be combined into a unified whole during patient consultation?" We can reassure you: the English and Canadians did this for us several decades ago. It's called the "Calgary–Cambridge Basic Model of Medical Consultation".

The Calgary–Cambridge Basic Model of Medical Consultation is widely known and used by most physicians in Europe and the USA because it thoroughly describes all stages of consultation. The guide provides detailed instructions and skills to help physicians build effective relationships with patients. The first edition of the Calgary–Cambridge Guides on communication was created in 1996 for medical educators and general practice physicians. Jonathan Silverman, a lecturer at the University of Cambridge, and Suzanne Kurtz, a professor at the University of Calgary, developed a partnership model that enhances satisfaction for both physicians and patients during the process of care provision.

The authors paid attention to a form of communication in medicine that promotes patient advocacy. The Calgary–Cambridge model includes 73 core skills that are useful for all physicians, regardless of specialization or level of qualification. These skills are helpful when

communicating with patients suffering from any disease. They are used both during outpatient consultations and medical rounds in hospital wards or when developing plans to improve the healing process. The model focuses heavily on verbal and nonverbal interaction skills, reactions that may arise throughout the entire meeting.

The main basic structure of medical consultation according to the Calgary–Cambridge Basic Model of Medical Consultation includes the following components:

1. Initiation of Consultation:
   - Preparation.
   - Establishing initial contact.
   - Identifying the reason for consultation.
2. Information Gathering:
   - Exploring patient problems (gathering complaints).
   - Biomedical aspect, or taking a medical history (sequence of events, clarification and analysis of symptoms, questioning about possible manifestations of the disease by organ systems).
   - Patient perspective (thoughts, fears, feelings, expectations).
   - Additional information (personal history, concomitant diseases, etc.).
3. Physical Examination (with mandatory patient consent and explanation of actions).
4. Explanation and Planning:
   - Providing necessary information about the health status and identified abnormalities to the extent necessary.
   - Explanation.
   - Achieving mutual understanding: taking into account the patient's opinion on the disease and their own condition.
   - Planning: jointly making decisions about examination and treatment.
5. Conclusion of Consultation:
   - Scheduling the next meeting.

The most important aspect of consulting according to the Calgary–Cambridge model is the continuous tracking by the physician of the progress of the consultation and the psychological state of the patient, structuring the stages of consultation, clarifying information for the patient, and supporting effective relationships.

The main goal of the Calgary–Cambridge model is to establish trusting relationships between the patient and the physician. To create an atmosphere of trust during the implementation of the Calgary–Cambridge Basic Model of Medical Consultation, the physician needs to learn to use three communication skills that permeate the entire dialogue from start to finish.

The first skill is managing "what the doctor says". These are the words and phrases the doctor uses for communication, when asking clarifying questions, explaining treatment tactics, etc.

The second skill is managing "how the doctor says it", their nonverbal expressions. This skill involves the process of communication itself. Here, everything matters because nonverbal communication never stops for a moment. If the doctor occasionally uses language when communicating, then with their gestures, posture, facial expressions, and gaze, they constantly communicate their presence and attitude toward the patient and the situation. Thus, the doctor demonstrates their emotions and attitudes to the patient. It is important for verbal and nonverbal information to be congruent (not contradict each other).

If during questioning the patient the doctor looks carefully into their eyes and calmly asks, "Tell me what prompted you to seek consultation right now. I am listening carefully", then the doctor's verbal and nonverbal signals match each other.

And if during the conversation the doctor's voice sounds tired, their gaze indifferent, distracted, eye contact is practically absent, although at the same time the doctor says that they are listening carefully, the patient cannot help but notice this. Contradictory information received by the patient from the doctor's facial expressions can cause feedback in the form of discomfort. Usually, this situation can lead to a disruption in emotional contact and a decrease in the level of trust in the doctor.

The third skill is self-awareness, or "what the doctor thinks and feels".

This includes empathy, attentiveness, decision-making ability, self-esteem, and self-confidence. Our perception will affect the content of the questions and how we structure the communication process. You may feel a variety of emotions — pain, sympathy, boredom, irritation. These feelings inevitably affect the quality of your

contact, so it is always important to be aware of them. By expressing support, informing about your feelings, track to ensure that the focus of attention remains on the patient, not on yourself. Remember that you are dealing with a sick person who is experiencing pain and anxiety about possible disability.

In our opinion, implementing this model into medical practice in Ukraine will push the effectiveness of medical communication in our country to a new level.

CHAPTER 3

BASIC CONCEPTS AND PRINCIPLES OF COMMUNICATION PSYCHOLOGY

The psychology of communication studies how people interact, exchange information, influence each other through language, non-verbal signals and other means of communication. Basic concepts and the principles of the psychology of communication help to understand how interaction between people takes place and how it can be made more efficient and satisfactory to all parties.

Communication: the exchange of information, ideas, and emotions between people using speech, gestures, facial expressions and other means.

Communication: a broader process of interaction that includes not only information transfer, but also interaction, influence and reactions.

Language: a system of symbols, sounds, and signs used to information transfer.

Non-verbal communication: facial expression, gestures, body position and other non-verbal means that convey information without language use.

Active listening: the ability to listen carefully and understand the interlocutor, demonstrating it through positive non-verbal signals and asking questions for clarification.

Empathy: understanding and compassion for the feelings and needs of another person.

Conflict: conflict of interests, opinions, or values that may arise during communication.

3.1. Fundamental Principles of Communication Psychology

Interaction: communication is a two-way process where both parties have the opportunity to influence each other.

Authenticity: communication is enhanced when people remain true to themselves and express their thoughts and feelings openly.

Context: understanding and interpreting messages can vary depending on the context in which they are presented.

Positivity: creating a positive and friendly atmosphere can improve the quality of communication.

Feedback: it is important to be able to receive information about how the other party perceives your message.

Tolerance for diversity: considering and respecting different viewpoints and cultural peculiarities helps build constructive interaction.

Positive nonverbal signal: your facial expressions, gestures, and other nonverbal cues can reinforce your words and positively impact communication.

Sympathy and empathy: showing interest and understanding towards the feelings of the other party can strengthen the connection.

These concepts and principles can be applied in various communication contexts, including professional, personal, and social interactions.

3.2. A Personality as a Tool

Using your personality as a tool is an important skill that can help you in various aspects of life, from your professional career to personal relationships. Here are several approaches to using your personality as a tool:

Self-awareness: Understanding your strengths, weaknesses, values, interests, and unique aspects helps you better understand yourself and your potential.

Communication: Your personality influences how you communicate with others. Use your language and communication style to reflect your individuality while considering the needs and expectations of your conversational partners.

Leadership: If you hold a leadership position, your personality can influence how you lead a team. It's important to be an authentic leader and use your qualities to inspire and motivate others.

Creativity: Your unique personality can be a source of creative ideas. Allow yourself to think outside the box and incorporate your personality into your creative projects.

Conflict resolution: The ability to understand and consider the feelings of others can help you effectively resolve conflicts and reach compromises.

Sales and marketing: If you work in sales or marketing, your personality can help you build relationships with clients and make your proposals more appealing.

Self-expression: Use your personality to express your views, ideas, and emotions through various means such as writing, art, or public speaking.

Collaboration: Your collaboration style can impact teamwork. It's important to be open to others' ideas and adapt your personality to achieve common goals.

Self-development: Use your personality as motivation for continuous self-improvement. Develop your strengths and work on improving your weaknesses.

Positive influence: Your personality can affect the mood and even the lifestyle of others. Use it to make a positive contribution to your environment.

The doctor's ability to use his personality as a tool is a key aspect of effective medical practice. A physician's personality can influence interactions with patients, staff, and the professional community. Here are some ways that can help physicians use their personalities to improve medical practice.

Empathy: Doctors can use their empathy to better understand the feelings and needs of patients. Showing understanding and sympathy can improve interaction and provide more effective treatment.

Communication: It's important for doctors to communicate clearly and understandably with patients. Use your communication style to create a favorable atmosphere and explain medical aspects in an accessible way.

Trust: Your personality can help build trust with patients. It's important to be open and sincere, share necessary information, and answer questions.

Interpersonal skills: Develop collaboration, listening, and communication skills with colleagues and other medical professionals.

Leadership: If you are in a leadership role in a medical team, use your personality to create a motivational and supportive work environment.

Professional development: Let your personality inspire you to learn and self-improve. It's important to stay open to new knowledge and practices in medicine.

Conflict resolution: The ability to resolve conflicts with understanding and tolerance can help create a harmonious work atmosphere and have a positive impact on patients.

Self-awareness: Reflecting on your personality and the impact you have on others can help you improve your practice.

Cultural sensitivity: Understanding and respecting different cultural, ethnic, and social aspects can provide better quality and accessible medical care for different patients.

Self-protection: It's important to be aware of your own limitations and stress factors. The ability to manage stress and rest well helps maintain the quality of medical practice.

Overall, effective use of a doctor's personality as a tool involves a balance of authenticity, professionalism, and a patient-focused approach.

CHAPTER 4
PSYCHOLOGICAL TYPES OF PEOPLE

The desire to describe the nature of human beings, their essence, internal conflicts, and behavior emerged in ancient times. Philosophers delved into these questions. Aristotle wrote the treatise "On the Soul" during antiquity. Hippocrates also classified temperaments, a classification that has survived to our time. Later on, efforts were made to systematize, describe, and explain psychological processes, to find regularities in human interactions with the natural and social world, to determine motives driving actions, and to explore personal experiences regarding the world, other people, and oneself. In 1879, Wilhelm Wundt established the world's first psychological laboratory, where consciousness phenomena were studied through introspection (self-observation).

However, let's not delve into the intricacies of history. Let's just say that today there are numerous branches of psychology aimed at understanding the essence of psychological phenomena, becoming aware of them, and coping with emotional, personal, and social difficulties. Psychology distinguishes various types of human behavior, and there are different classifications, such as aggressive behavior, social behavior, antisocial behavior, autistic behavior, and many others. Most of these classifications are used for understanding and diagnosing various mental disorders and problems. Undoubtedly, a doctor during a consultation may encounter any of them. Many factors influence personality behavior, but the most influential are a person's psychotype, upbringing, environment, and the presence of any diseases.

By nature, a person only receives the potential for development in a certain direction. This potential is based on the anatomical and physiological features of the human brain and endocrine system at birth. Individual characteristics of a person develop on this basis, including temperament. Temperament refers to stable individual personality characteristics expressed in the dynamics of mental processes and actions. Temperament traits include the strength

and weakness of feelings and desires, their depth or superficiality, the stability or variability of mood, the accelerated or slowed pace of action execution, and activity or passivity demonstrated by a person when faced with obstacles. Temperament affects personality traits such as vulnerability, emotionality, impulsivity, and anxiety.

Vulnerability refers to the degree of influence various stimuli have on a person, the duration of their retention in memory, and the intensity of the reaction to them. The same stimuli have a greater impact on a vulnerable person than on a less vulnerable one. Additionally, a vulnerable person remembers the corresponding action longer and retains the reaction to it for a longer time.

Impulsivity manifests in unrestrained reactions, their spontaneity, and their appearance before a person has time to consider the situation and make a rational decision on how to behave. An impulsive person reacts first and then thinks about whether their actions were correct, regretting premature and incorrect reactions.

Emotionality refers to the speed and depth of a person's emotional reaction to events. An emotional person attaches great importance to what is happening to them and around them. This can manifest in bodily reactions occurring during emotional states. An emotional individual is never calm, constantly experiencing any emotions, in a state of heightened excitement or, conversely, depression.

An anxious person is in a constant state of worry and fear. They believe that most of what surrounds them poses a threat to their own "self".

In 1968, Hans Eysenck published a questionnaire to determine individual psychological traits. The methodology contains four scales (picture 1): extraversion, introversion, neuroticism (emotional stability, instability), and psychoticism (inadequacy of emotional reactions).

The typical extravert is described as someone who requires a high degree of interpersonal relationships. They are sociable, cheerful, optimistic, impulsive, fiery, and prefer movement and action. Their feelings and emotions are not under strict control, and they tend to engage in risky behavior.

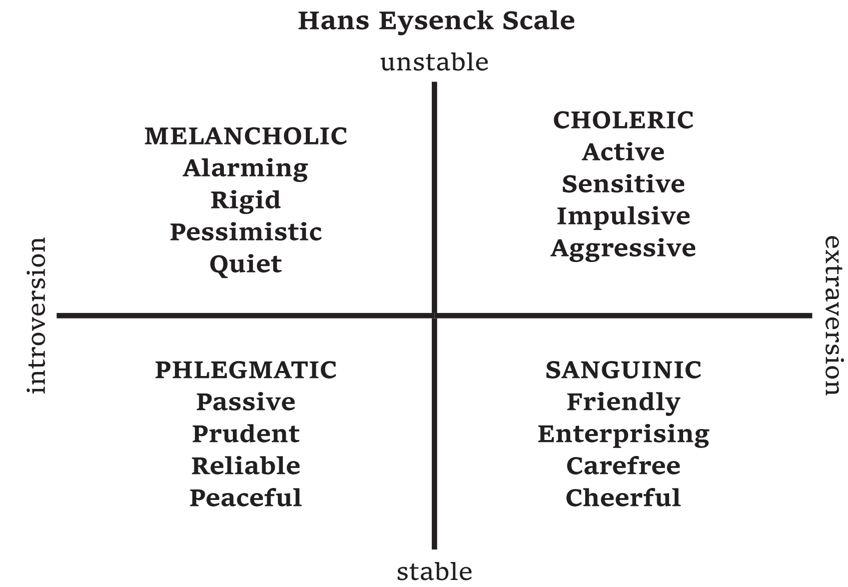


Fig. 1

Typical introverts are calm, reserved, pessimistic people, prone to reflection (introspection), distant from everyone except close friends Those who love order. They plan their actions in advance and do not trust sudden urges that are serious relate to decision-making. They are not easy to get out of yourself, they control their feelings.

Neuroticism — emotional stability (preserving organized behavior in normal and stressful situations, adaptation, tendencies to leadership) or instability (tendency to quickly change mood, feelings of guilt, anxiety, depression).

Psychoticis — high conflict, egocentricity, indifference, tendency to antisocial behavior.

Using this technique, you can determine the type of temperament and pronounced character traits.

Thus, we get four sectors, which denote behavioral features. Cholerics included energetic, fiery, "passionate" people. Melancholics were called timid, indecisive, sad; phlegmatic — slow, calm, "judicious".

Sanguines were considered mobile, cheerful, "alive" people.

Phlegmatic is more difficult to form in oneself than choleric or sanguine initiative and determination.

For a melancholic, overcoming fear and anxiety is a serious problem. According to Eysenck, high scores of extraversion and neuroticism

correspond to hysteria, while high scores of introversion and neuroticism correspond to a state of anxiety and depression.

Temperament traits can either counteract or contribute to the development of certain character traits. Character is the set of stable individual personality characteristics, the "special features" that a person acquires while living in society. The formation of character is influenced by social groups (family, school, friends, antisocial groups, etc.). Knowing a person's character allows us to speculate on how they will behave in different circumstances. Character, like temperament, depends on a person's physiological characteristics. In the same conditions and with the same interests, a person may behave differently: softly, decisively, intolerantly, cheerfully, sadly, confidently, or timidly, adaptively or non-adaptively.

Modern psychoanalyst Nancy McWilliams has been able to describe the complexity of human personality and has created a typology of characters. The experience and knowledge she shares enable understanding differences and building effective relationships in the "doctor-patient" dyad.

According to Nancy McWilliams, personality can be:

— Neurotic level (people who have the ability to function at a high level despite some emotional suffering. The nature of the difficulties lies in the internal conflict between desire and obstacles, which these clients themselves assume are their own responsibility).

— Borderline (intermediate) level.

— Psychotic level (people with a psychotic personality structure are internally empty and disorganized. They are in a state of panic, feel unprotected, interpret neutral statements or statements about other people as having negative implications for them, illogical thinking).

There are also conditionally healthy individuals. In the "healthy neurotic" range, one can live normally, have a more or less realistic self-image, a stable self-esteem, adapt in society, and be capable of building and maintaining close relationships.

The personality types presented below are considered in a clinical context, but the expression of a particular psychotype can be represented at different levels — from neurotic to psychotic. Moreover, the same person may exhibit features of several types.

Antisocial (psychopathic) personality type: aggression, anger, impulsivity (immediate reaction), a desire to avoid experiencing

weakness, envy, low social intelligence (inability to empathize, talk about their feelings), a need for experiences that "shake" to feel cheerful.

Effective strategy — firmness, acceptance of human nature, realistic understanding that sociopaths can be dangerous.

Narcissistic personality type: inner feeling of fear, shame, weakness. Unstable self-esteem, self-doubt. Tendency to self-condemnation and evaluation. Intolerance of criticism, especially public criticism. Feelings of emptiness, incompleteness, or compensatory opposites — self-assertion, sense of self-worth, disdain, arrogance. Perfectionism, compromise problems. Hypochondriasis (concern for their health, fear of death).

Effective strategy — patience, non-judgmental, realistic attitude.

Schizoid personality type: increased sensitivity leads to prolonged reflections, fantasies. Often establish distance, detachment, as closeness is associated with harmful influence on their own "self".

Effective strategy — delicacy, respect, empathy.

Paranoid personality type: suspicious, distrustful, with a lack of sense of humor, egocentric (focused on themselves, believe that everything that happens relates to them). Have an excessively developed sense of grandiosity (but from here comes a sense of guilt, "If I am almighty, then all unpleasant things mean my failure"). Unable to relax, constantly tense. Obsessed with the need to reinterpret everything, criticize. Provoke aggression.

Effective strategy — preventiveness, providing answers to their questions rather than avoiding them, heightened sense of boundaries.

Depressive personality type: feel concerned about their destructiveness, believe that they deserve to be treated poorly as soon as others get to know them better. Low activity, high fatigue, anhedonia (inability to enjoy ordinary pleasures). Sleep problems. Extremely vulnerable, rarely experiencing feelings of aggression and anger.

Effective strategy — kindness, respect, patience. Realistic self-attitude, not so much to support with praise as to attack self-criticism. Interpret actions as achievements.

Manic personality type: high sociability, tendency to idealize. High speech rate, gestures, sense of humor. Mobility (as a sign of anxiety).

Effective strategy — respect, patience, delicacy. Often interrupt treatment after improvement.

Masochistic (self-destructive) personality type: consider themselves suffering, but undeservedly. Make an impression on others as demanding and contemptuous, exalted in their suffering, contemptuous of ordinary mortals who cannot endure the same strong grief with the same sophistication. Complain openly. Take a victim position (looking for a savior and see a "persecutor", guilty). Get hidden pleasure from their sufferings. Perceive compassion from others as value. Unlike the depressive, see "evil" not so much inside themselves as outside (resembling a paranoid personality type). Love to be sick but not treated.

An effective strategy is patience, avoiding the role of savior. Behaving like an adult.

Obsessive-compulsive personality type: motto — "Don't feel, just do". Meticulous, punctual to pedantry. In their pursuit of control, they can be excessively persistent. They have difficulty expressing emotions. Secretive.

Effective strategy — the first requirement is to maintain friendliness because they tend to irritate others, not fully understanding the reason for their behavior. Encourage expression of feelings.

Histrionic (theatrical) personality type: demonstrative, artistic, initiative, intuitive. Inclined to influence. They have a tendency towards mysticism and superstitions. They interact differently with men and women. The main feeling during hysteria is that of a small and frightened child.

Effective strategy — gentleness, respect, patience.

In conclusion, it is worth remembering that by following the rules of interaction between a doctor and a patient, any complex moments can be smoothed out because they are relevant to each patient.

To establish and maintain contact, a doctor should:

1. Create an atmosphere of trust: warmly welcomes the patient, clarifies expectations and problems the patient would like to discuss, listens attentively, discerns signals, checks assumptions.

2. Acknowledge the legitimacy of the patient's views and feelings, without condemning, support the patient's expression of their feelings and thoughts.

3. Show empathy to express understanding and respect for the patient's feelings and difficulties, openly acknowledge the value of their views and feelings, even if these feelings or fears are unfounded or even mistaken.

4. Provide support: cares, understands, shows willingness to help, offers partnership.

5. Show sensitivity — this means, approach delicately to delicate and unpleasant topics and physical pain.

It is extremely important for a doctor to have fundamental knowledge of psychology, understand how the patient perceives the changes that occur during disease, effectively respond to emotional manifestations, engage the patient in the healing process, and realize their role in the counseling process. The patient may feel vulnerable and react impulsively because disease is stressful for the body. A sensitive doctor may experience a whole range of emotions towards the patient because each encounter is a "challenge". But there is another side to the "coin": through compassionate and respectful acceptance of others, you may open up access to understanding and accepting the dynamics of your personality, find inspiration in your work.

Regarding the patient's behavior in a medical context, it may manifest in different types depending on the state of health, diagnosis, and other factors (physical condition, mental state, emotional state, and social environment). Here are some general types of patient behavior.

Cooperative behavior: patients demonstrate cooperation and a positive attitude towards doctors and medical staff. They follow medical recommendations, adhere to the treatment regimen, and interact with specialists to improve their health.

Aggressive behavior: patients may be aggressive or hostile in relationships with medical staff or other patients. This behavior may be caused by fear, pain, or other emotional or psychological factors.

Passive behavior: patients may be passive and indifferent to their health status or treatment. They may not follow medical recommendations, initiate treatment, or interact with medical procedures.

Adherent behavior: adherence means adherence to medical recommendations and treatment regimens. Some patients may be adherent and are characterized by following all of the doctor's instructions, taking medications on time, and following other recommendations.

Seeking behavior: patients may actively seek information about their health status and possible treatment methods. They may use

the internet, consult with other medical professionals, or ask many questions to their doctor.

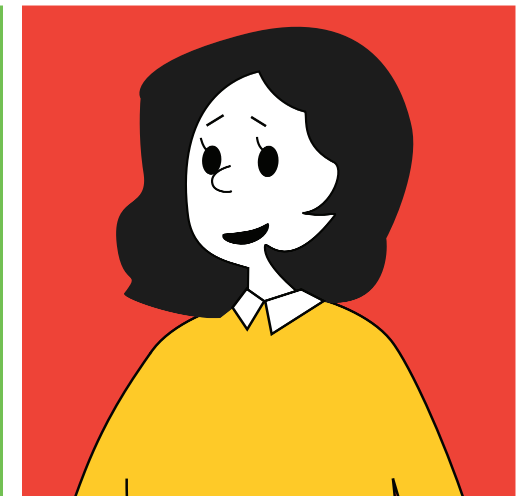
Refusal of treatment: patients may refuse treatment or procedures, even if they are recommended to improve their health. This can be a challenging problem for medical staff.

Emotional reaction: patients may demonstrate various emotional reactions to their health status, such as fear, anxiety, depression, or dissatisfaction.

It is extremely important for the doctor to have skills in quickly recognizing the patient's psychotype and influencing their behavior because, regardless of their behavior, every patient who seeks help wants to receive it in the best possible way. The patient will never blame themselves for a negative outcome. Therefore, all this knowledge is necessary for the doctor not only to truly provide high-quality assistance, conduct a certain psychological consultation, but also to protect themselves from attacks and legal consequences of reactions of individual patient types. Medical staff should take these factors into account when interacting with the patient and developing a treatment plan.

CHAPTER 5

A STORY OF HANNA



5.1. ARVI and the CLASS Protocol

Hanna's story started very banally. With a simple acute respiratory viral infection (ARVI). During the COVID-19 epidemic. One morning, Hanna woke up feeling itching and discomfort in her throat. She was worried that such pain might be related to this terrible disease. Hanna was in a panic. A few days ago, she had been at the funeral of a neighbor who died from COVID-19 pneumonia. Hanna measured her temperature, seeing it elevated to 37.2°C, she felt even worse. Being beside herself from fear, Hanna called an ambulance, the dispatcher of which advised her to see a family doctor (Fig. 2).

Fig. 2

Hanna called the family doctor. She was very worried that she was seriously ill and her condition might worsen, so she begged the doctor to come to her home as soon as possible. But the doctor convinced Hanna to come to the polyclinic and made an appointment on the same day (Fig. 3).

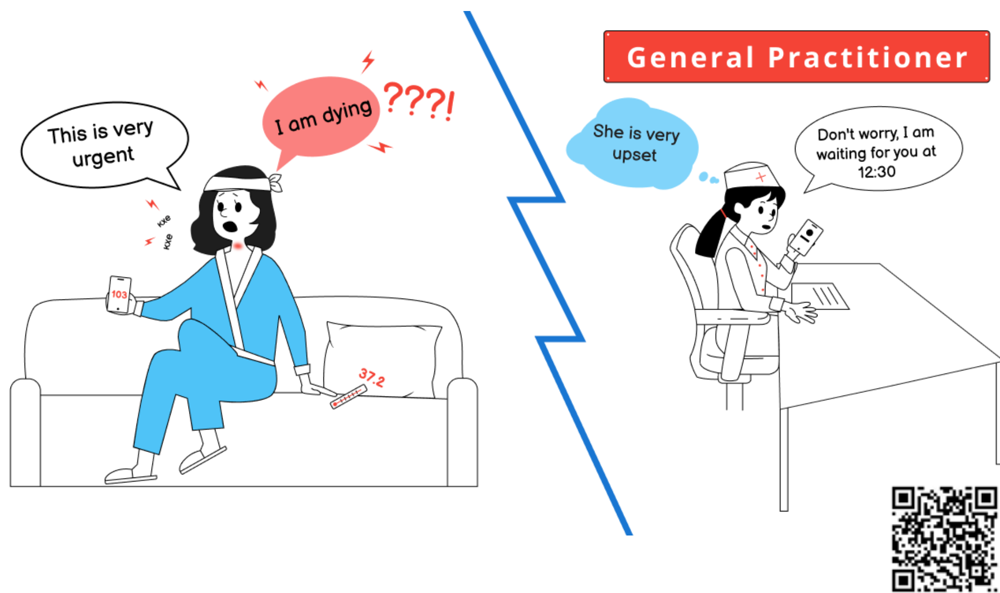


Fig. 3

When Hanna came to the clinic, she didn't know why she felt worse: from a cold or from fear. After seeing a doctor, Hanna felt some relief, without even realizing why. Maybe it was the doctor's smile, or the pleasant atmosphere in the office (Fig. 4).

Fig. 4

We see the implementation of the first step of the protocol CLASS called "Space Organization" (letter C — Context).

!!!	Environmental factors significantly affect the physical and psychological comfort of a person.

The environment, lighting, and room temperature are of great importance.

It is useful to arrange furniture so that the doctor and patient are positioned at an angle rather than directly opposite each other. Such positioning promotes the establishment of partnership relations.

In the first few minutes of communication, a first impression is formed, which prepares ground for further interaction.

At the beginning of the conversation, the doctor should set aside other tasks (such as completing the previous patient's chart), maintain eye contact, and speak in a friendly manner that matches facial expression.

The doctor should adopt an open posture (in which the doctor sits or stands with arms and legs uncrossed, may gesture with hands during conversation, indicating the trusting and supportive attitude towards the patient).

Neat clothing is of paramount importance.

Although Hanna felt some relief, her posture was tense and agitated facial expression immediately demonstrated the high level of her nervousness and suffering. Despite everything, Hanna saw that the doctor was looking at her with kindness and attention (Fig. 5).

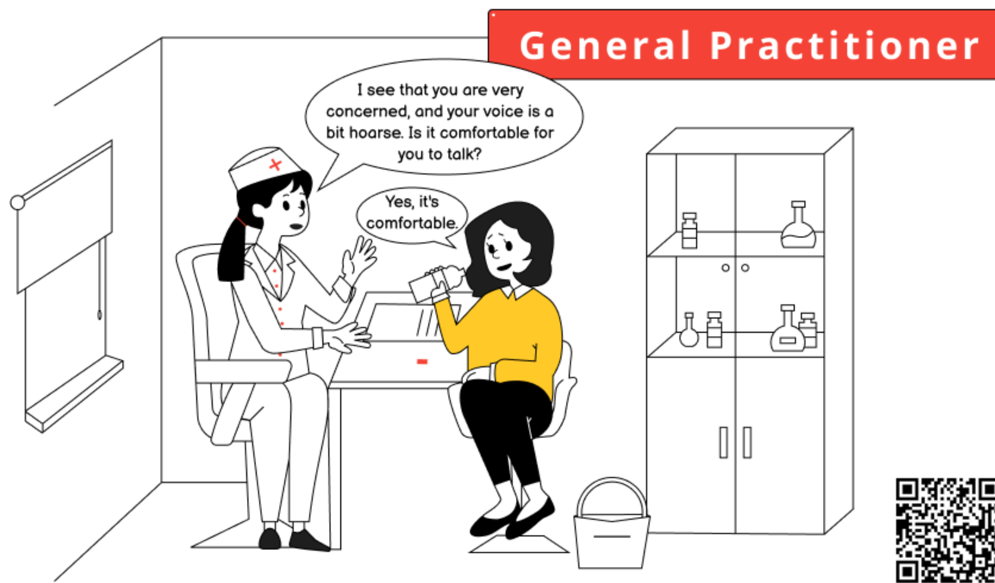


Fig. 5

Such an attitude calmed Hanna even more and made her think that everything will be fine.

Therefore, when Hanna turned to the doctor with the words, “Anastasie Ivanivno! Save me, please! I don’t want to die!”, she already clearly understood that no one would let her die now.

!!!	Establishing the first contact with the patient will affect all subsequent relationships.

This process can easily be hindered by a previous meeting of the doctor with the patient or a colleague, a phone call, unresolved household chores, feeling of hunger or fatigue.

If there is a need, the doctor can take a few minutes to take care of himself and set up himself for a new appointment without haste.

For the patient, this important and significant event will be more useful if the doctor responds with full attention.

Such simple techniques of politeness as greeting the patient, if necessary, self-introduction, clarification of name, surname and questions about how better to turn to him, as well as care for the physical patient’s comfort (convenience of location, screen), show respect and make communication a lot easier.

!!!	When establishing contact, it is very important to inform the patient in advance about time limits, if any.

Hanna's feelings began to change, and excitement was replaced by slight shame: Hanna remembered that in the phone conversation pressed the doctor too much.

Therefore, she expected to hear something about it at the beginning of communication, but everything turned out differently.

The doctor was very friendly and attentive.

Her body position, calm tone of voice, appropriate pace of speech and eye contact showed a friendly attitude from the first seconds of contact and mostly put Hanna at ease (Fig. 6).

Fig. 6

The doctor turned to the second step of the CLASS protocol — Effective listening to gather information (the letter L — Listening skills). This step includes active skills hearing:

1. *Non-verbal skills of the doctor:*
   — *considerate behavior for building relationships;*
   — *open body position;*
   — *providing space (distance);*
   — *eye contact;*
   — *tone of voice that corresponds to facial expression;*
   — *appropriate pace of speech.*
2. *Attention to verbal and non-verbal signals of the patient and the reaction to them.*
3. *Facilitation (involvement of the patient in active participation in the process of treatment).*

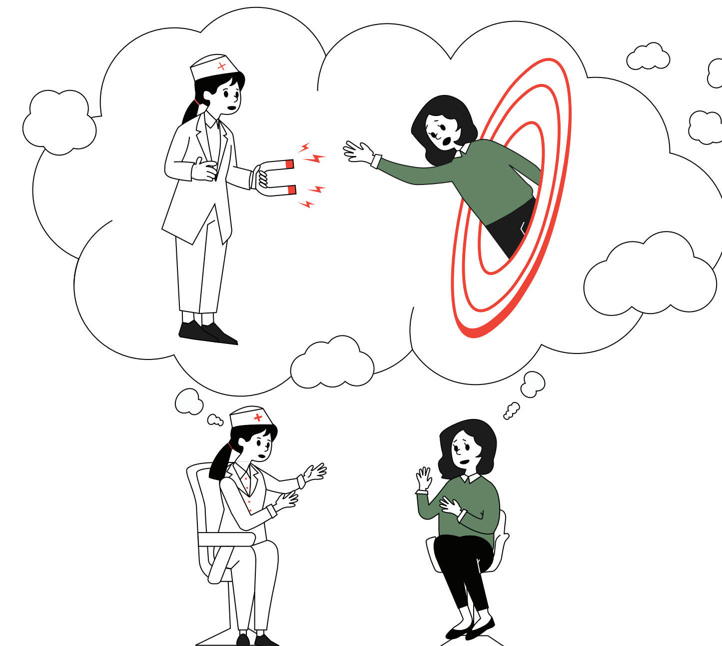


Fig. 7

The first useful digression

Facilitation is an approach by which the doctor helps the patients take a more active role in their treatment, understand their condition, and make an informed decision about their health. During facilitation, the doctor encourages the patient to provide more information on a specific topic and demonstrates empathy, respect, understanding, attention, unconditional acceptance, and tolerance towards the patient, helping to inspire optimism and trust.

The main principles of facilitation in medicine include:

Informing: The doctor provides the patients with comprehensive information about their condition, diagnosis, possible treatment methods, risks, and benefits of different approaches. This helps the patient in making informed decisions.

Listening and communication: The doctor takes time to listen to the patient, his preferences, questions, and discussion of fears or unclear points.

Shared decision-making: The patient is not only involved in the decision-making process regarding diagnosis, treatment, and care plans but also realizes his own responsibility for recovery. The doctor helps to explore all aspects of the decision and its consequences.

Patient education: Medical staff provides patients with understandable information about his health, diagnosis, treatment, and procedures. This helps patients better understand how to take care of themselves.

Support for self-protection: Patients learn to independently recognize signs of deterioration in their condition and seek medical help promptly (Fig. 7).

Facilitation combines verbal and non-verbal communication skills:

— encouragement — nods of the head, appropriate facial expressions, gestures, exclamations of “huh”, “yes” and others when the patient is talking;

— a pause helps the patient to continue the conversation, express thoughts and feelings out loud;

— repetition of the last few words of the patient, gently guides the course of the consultation;

— paraphrasing (retelling in your own words) is used as a check of whether you understand the patient correctly, helps to express support, generalize, clarify the patient’s condition;

— the doctor communicating his thoughts is a way to express empathy and involve the patient in the consultation process.

Thus, facilitation is aimed at strengthening cooperation between the doctor and the patient, providing greater openness, understanding and trust.

Facilitation helps to improve the patient experience, helps to increase the level of satisfaction with the provided medical care, and improves the timing and results of treatment.

Hanna realized that she would easily tell the doctor everything she asked about.

During Hanna's story about her condition, the doctor periodically nodded and responded with exclamations of "yes" or "good", which gave Hanna confidence that the doctor really cared about her and wanted to help her (Fig. 8).

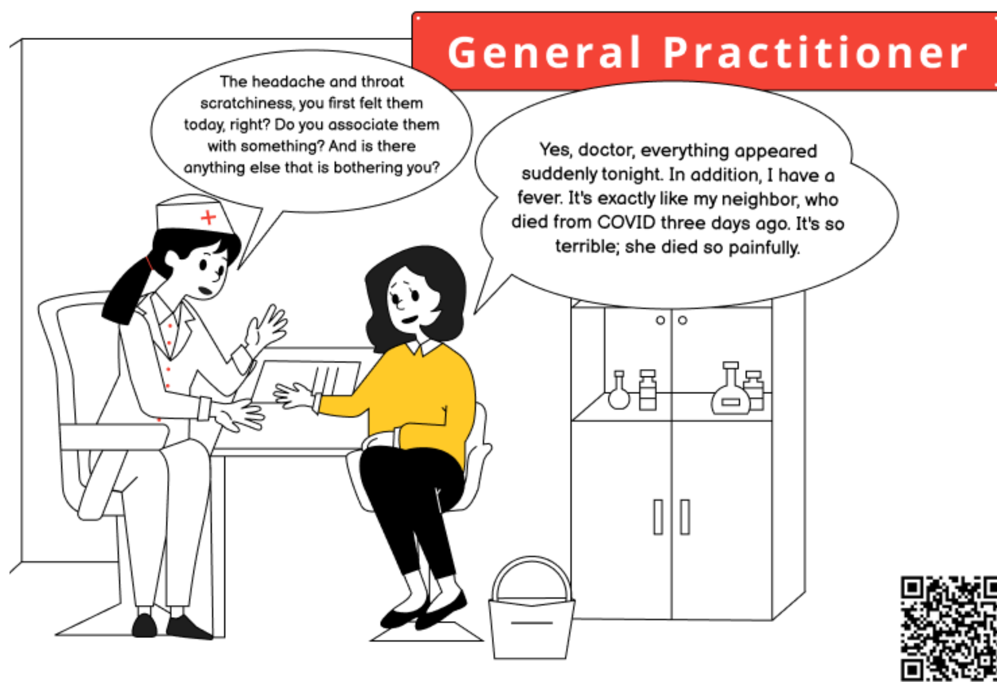


Fig. 8

!!!	When establishing contact, it is important to find out the reason for visiting a doctor.

The doctor asks the patient to tell about complaints, finding out why the patient turned to the doctor today of all days.

It is advisable to start studying the patient's problems from the following phrases, "What reason made you apply to me?"; "How can I help you?"; "Answers to what questions would you like to know?" — and give an opportunity tell the patient without interrupting or directing conversation starter/

Open-ended questions are necessary to achieve the doctor's general view of the reason for the patient's application.

!!!	In further counseling, the doctor should lead the conversation, but it is recommended to listen carefully, without interrupting and allowing the patient finish the sentence.

The retelling of complaints is also an important component that the patient makes in clarifying the details of the history. This further confirms to the patient that the doctor's attention is focused on him or her.

And when the doctor offered to discuss the plan with Hanna examination and treatment, she felt like a very important part of the process. Hanna understood that she is the main person in the fight against the disease, and the doctor only helps and suggests the best way. Therefore, Hanna happily agreed to the examination and further discussion (Fig. 9).

Fig. 9

The next step of the CLASS protocol is "Exploration and identification of the patient's reaction" (the letter A — Acknowledge). At this stage of communication, the importance of using both non-verbal (visual contact, facial expressions, posture, pose, gestures, pace, voice volume, intonation), and verbal speech (paraphrasing, clarification) is maintained.

The patient can present at once several important, unrelated complaints.

!!!	It is important to understand the patient's thoughts about his condition, his attitude to the disease and its consequences, and how the problem affects his life.

It is very important to find out all the patient's expectations and what kind of help he wants from you.

During the inspection, in addition to professional actions, very important psychological components are delicacy and involving the patient in the process — a constant explanation of the doctor's actions.

Screening is another component of this step of the CLASS protocol, which is necessary for structuring the consultation — a method of summarizing complaints, definition priority and making a plan for additional examination and treatment that will be understandable to the patient, involving his to the therapeutic alliance.

While examining the patient, the doctor constantly commented all her actions and talked about the intermediate results of the examination, adding comments. Hanna understood her condition with every minute is getting better. As the examination came to an end, Hanna gradually calmed down, because she understood that there was nothing to worry about, and she had no coronavirus infection (Fig. 10).

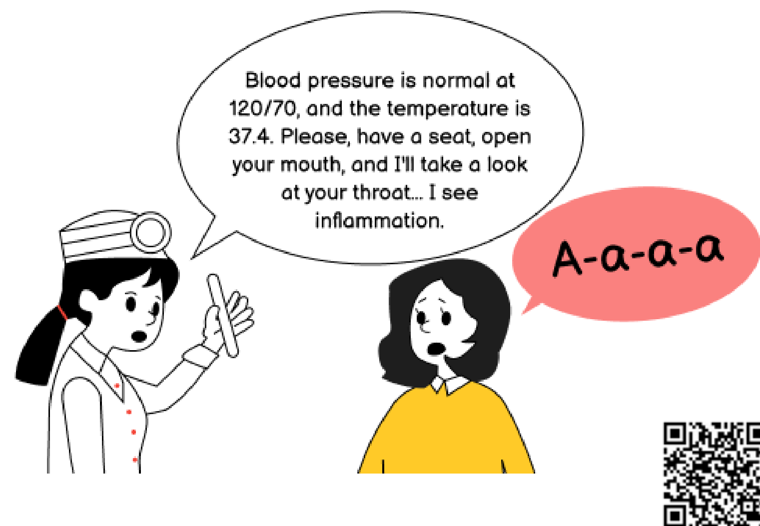


Fig. 10

Previously, with the traditional approach, the disease was considered as the cause of the malaise consisting of symptoms which should be put together (that is, as a "broken thing", which need to be fixed).

!!! Today, the patient-oriented approach implies an important place for paying attention to the patient's emotions, how the disease affects the patient's quality of life, his relations with the family, whether there is a desire and forces to apply various restrictions and adhere to the treatment regimen.

Very often, due to lack of time, the doctor takes the initiative into his hands, and the patient turns into a passive information provider. Patients, trusting the competence of the doctor, waiting for clarifying questions regarding diseases, assuming that if the doctor does not put them, then they don't matter.

However, unfortunately, the doctor, without asking detailed questions, delves into the diagnosis rather than listening to the patient, although it can cover a wider problem and gain more information to establish a correct diagnosis.

The doctor told Hanna that she had a mild cold, but considering that a routine examination is not enough to establish a final diagnosis, to clarify the diagnosis, she offered to pass additional tests on the first floor of the clinic, where the appointment was held.

Also, before receiving the results of the laboratory examination, the doctor recommended Hanna to drink plenty of warm water, gargle with chamomile solution, and take paracetamol (Fig. 11).

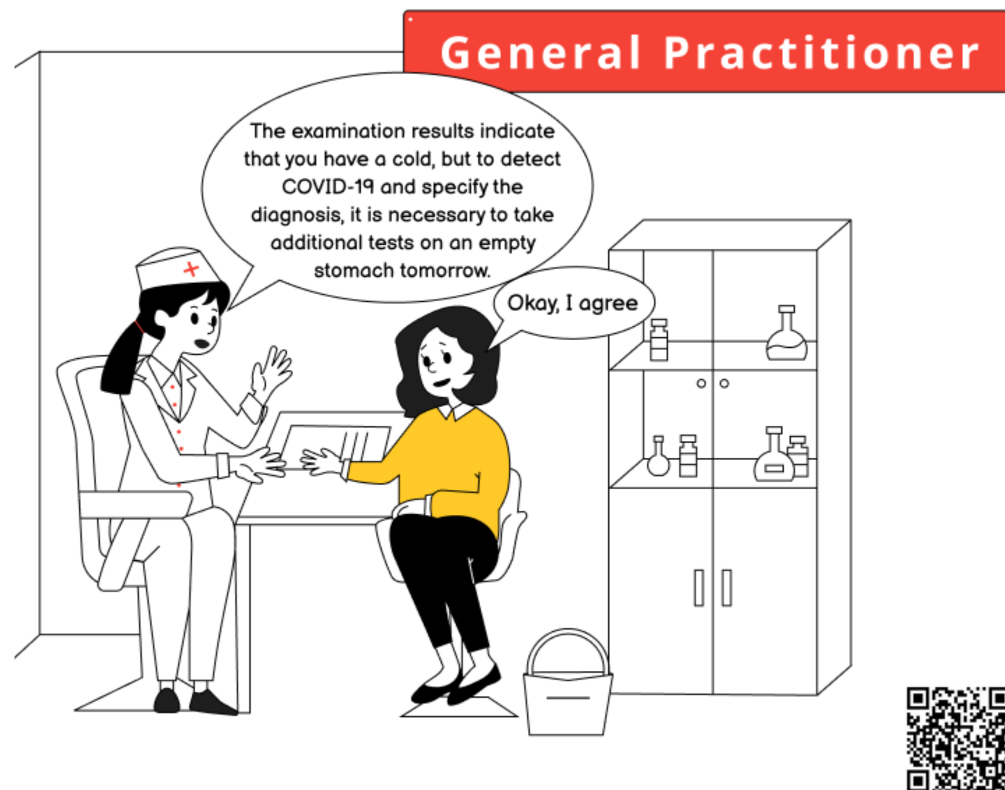


Fig. 11

The next step of the CLASS protocol is "Explanation and planning" (letter S — Strategy).

!!!	At the stage of explanation and treatment planning, all the necessary information must be provided by the doctor in a sufficient amount.

During the consultation, the doctor must constantly monitor the verbal and non-verbal signs, which give an opportunity to assess the patient's reaction to the provided information, find out if the patient understands the doctor's words correctly and does not require explanations or additional information.

To facilitate the perception of information by the patient it must be presented in simple, structured language in a logical sequence. Complex medical terminology is usually incomprehensible to the patient, so it should be replaced with simple concepts and, if necessary, the information provided should be repeated.

We remind you that one of the most important components of successful treatment is the active involvement of the patient in the treatment process, giving him the active role of co-creator of his own health, rather than a passive follower of the doctor's prescriptions.

After learning of additional tests that should disprove any fears of a serious infection, Hanna was completely reassured, and her mood improved significantly. She was ready to agree on everything that the doctor suggested. And she gave her consent to all examinations and proposed treatment (Fig. 12).

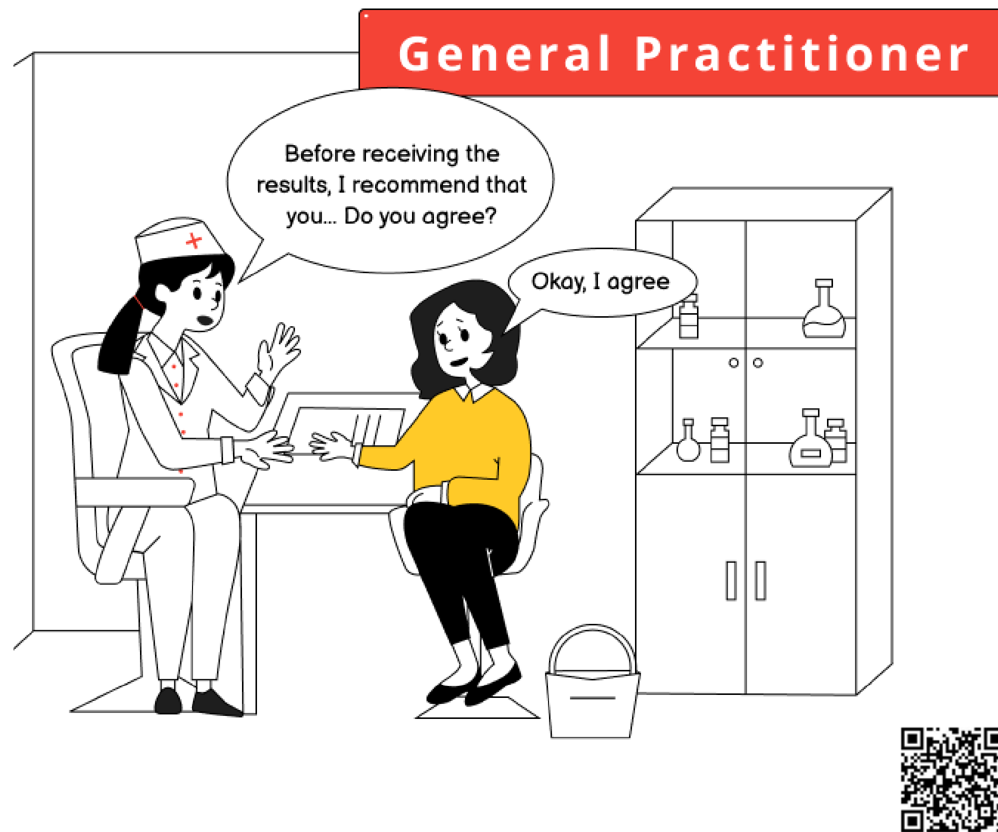


Fig. 12

It is necessary to involve the patient in an active role still at the planning stage of examination and treatment, discuss the advantages and disadvantages of different methods of examination or treatment and side effects.

!!!	It is necessary to give the patient an opportunity to choose the method that, in the patient's opinion, will be the most effective for him.

It is necessary to agree on further actions. The patient should receive information on what to do in unexpected cases, when and how to refer to help.

Discussion of investigations and procedures should take place in a way that is understandable and accessible to the patient. It is necessary to clearly explain how the procedure effects on the accuracy of the diagnosis or the effectiveness of the treatment, its importance and purpose.

The patient should be explained the whole process of the procedure, peculiarities of preparation for it, what sensations are possible, how and where the result can be obtained.

Check the patient's understanding of this information. Coordinate the treatment plan with the patient. Decide which plan of the treatment will be the best for the patient.

When at the end of the appointment the doctor gave all the necessary recommendations for further examination and treatment and offered to come for a follow-up appointment in a few days, expressing the hope that Hanna would have recovered by then, Hanna's good mood was finally restored. Hanna thanked the doctor and went home in a good mood, even though the road to health was just beginning (Fig. 13).

Fig. 13

The next and last step of the protocol is termination consultations (letter S — Summary). The task of this consulting step — summarizing, drawing up further action plans, in particular patient routing.

This step is no less important than the first one.

> **!!!** Instructions to the patient are very important in case something goes wrong.

Of course, only 16% of patients are asked by doctors if they have additional questions, and few ask whether the patients sufficiently understood the received information.

Therefore, if the patient did not have time to tell all his complaints during the consultation, at the end something unexpected may come up during the consultation, for example, "Yes, by the way, I wanted to tell you..."

To clarify whether the patient has understood all the information provided, we recommend asking questions, such as "To make sure we understand each other correctly, I ask you to repeat the basic guidelines that are important to follow at home..."

5.2. ARVI is not ARVI, Emotions, the BUSTER Protocol and the CONES Algorithm

Hanna returned home and began to carefully follow the doctor's recommendations. However, she decided that she would not go for a blood test tomorrow, because the doctor confidently said that she had a cold.

She persistently continued her treatment for 10 days, иut it seemed to her that there was no result. Hanna looked at her throat every morning after gargling. In the reflection of the mirror, she saw that the redness in her throat was gone. However, the itching and body temperature did not change at all and continued to bother her (Fig. 14).

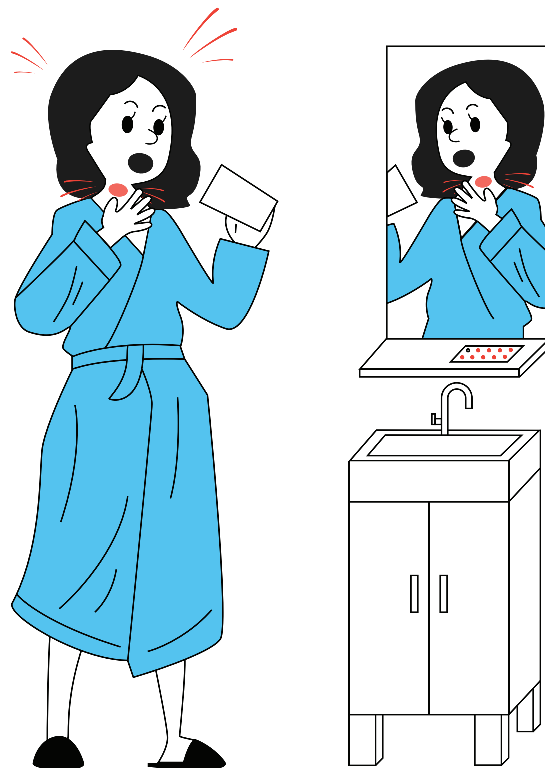


Fig. 14

Hanna decided to go to the doctor and express everything that had built up inside her and then find another, more qualified professional who could help her. When Hanna came to the polyclinic, she was so irritated that without paying attention to a possible turn to the doctor, she flew into the office without knocking, opening the door wide. Her appearance showed irritation and dissatisfaction (Fig. 15).

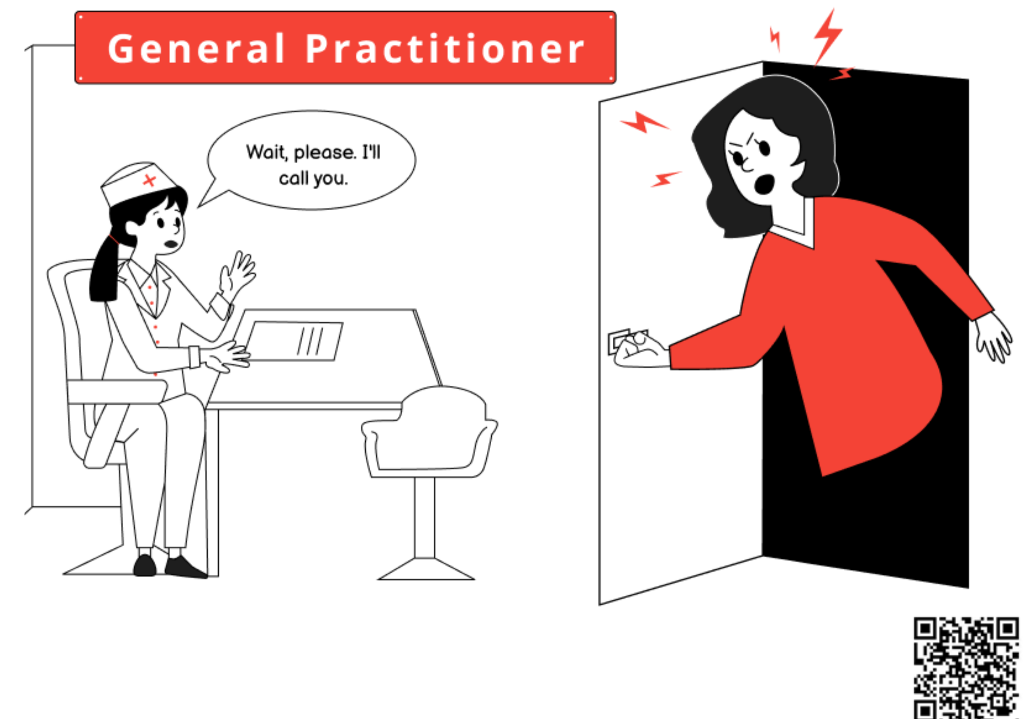


Fig. 15

Posture of the doctor with a straight back, not leaning on the back of the chair, the relaxed facial expression showed calmness and confidence, which had a chilling effect on Hanna.

The doctor greeted Hanna and asked to give her a few minutes to finish the previous case, waiting outside the door. At the same time, the doctor assured Hanna that she would call her as soon as she was free.

Although the doctor still did not understand the reason for this mood in Hanna, she did several exercises to prepare for difficult communication after Hanna left the office. This was one of the techniques of mindfulness (Fig. 16).

Fig. 16

Emotions of fear, anger, sadness can make it difficult to provide medical care. The patients react emotionally and behaviorally to their own disease, so doctors should respond adequately to these reactions. It is very important to remember at such a moment that you are dealing with a person who feels physical or psychological suffering. Very often the behavior of the patient reflects his emotional state. So, having processed the emotional reactions, we can also indirectly change the patient's behavior, which probably interfered with the treatment process.

Hanna feels powerful emotions, reveals them, it can hinder effective communication. These emotions and behaviours tend to evoke negative feelings in the doctor as well, which can lead to conflict and loss of contact with the patient.

Therefore, in this situation, the doctor chose one of the most effective means of changing the situation — BUSTER protocol, which is used for complex emotional conversations with the patient and his relatives.

The doctor shows us the first step (the letter B in the name protocol means Be prepared — "Get ready"). The purpose of this step for the doctor is recognition of his unconstructive and destructive emotions and their minimization. Hanna felt a sense of aggression due to the lack of satisfaction of her needs, against the backdrop of the failure of the result she received to meet her expectations. In addition, in this case, Hanna's anger and aggression, which she displays, hide her true emotions of sadness from the continuation of the disease and fear of death from it.

Therefore, the main goal of the doctor throughout communication is a decrease in the degree of aggression (or complete its removal) and elimination of sadness and fear. This is a very difficult task, and the doctor will not be able to perform it in a state of irritation or corresponding aggression. Therefore, the doctor immediately realized the power of her negative emotions, used the mindfulness technique for recovery and increased the level of emotional balance.

But let's go back to our story. In a few minutes the doctor adopted to effective communication. She stabilized her emotional condition and prepared for a difficult conversation. Mindfulness technique helped the doctor to take control of her awareness in thoughts, emotions, feelings, bodily feelings and the surrounding situation. The doctor became able to control her feelings (the heart beats evenly, hands do not tremble, breathing is smooth) and to consciously decide how best to respond to the patient's behaviour. The atmosphere in the office, prepared as usual, also contributed to the transfer of communication in a favourable direction and goodwill — a warm bright room, where there are no extraneous sounds.

The second useful digression

In a broad sense, mindfulness is a special ability to perceive everything that is happening right now, in the proper way, it is an ability to accept everything that happens with you, any situations, it doesn't matter if they are sad or even unpleasant, and go through, experience these situations without much harm to yourself, but not to hide from them, procrastinating and being under constant stress. This technique involves choosing a conscious life and following a goal, being psychologically prepared, being attuned to surprises and being true to one's own value orientations.

A simplified version of the mindfulness practice is provided as the following steps:

1. For those who are starting, it is better to under comfortable conditions, in a quiet room where no one disturbs you. Eventually, mindfulness will not require such seclusion, but it is desirable to achieve silence from those around you. It is very important to learn to feel comfort exactly where the mindfulness is used (you can at least imagine this comfortable place).

2. It is necessary to assume a sitting position with a straight back, resting your feet on the floor. The beginners should close theit eyes, but in time the eyes may remain open. The spine should be straight and free, standing on nothing.

3. Looking ahead, it is necessary to do 3–4 deep breaths through the nose and exhalations through the mouth.

4. In the next step, it is necessary to return to normal breathing, but monitor each respiratory movement. The eyes must be open. It is during this step that you can count to 6 or 10. During counting, you must try to feel your body, its pressure on the chair and feet's pressure on the floor.

5. During the previous step, you may have different thoughts, the brain begins "wandering". It is quite normal, but you have to gradually return it to a state of rest. It is important to realise that it is not your thoughts that control you, but you control your thoughts. The most important component of mindfulness is a skill of noticing your thoughts and then refocusing on the breath, preventing self-criticism..

6. At the end of the mindfulness session, it is necessary to gradually feel your whole body and begin to hear the environment.

If you liked this practice and you felt the need to apply it in your everyday life and work, you can master it thanks to our other textbook, which is dedicated specifical Mindfulness-Based Cognitive Therapy (MBCT) for the practice of doctors of all specialties.

When psychic adaptation was completed and the doctor felt her balanced state, she invited Hanna to come into the office. Hanna understood that the doctor saw her mood and dissatisfaction, however the doctor continued to be friendly and the expression on her face was calm. This somewhat reduced the degree of aggressiveness, and although Hanna was still irritated, she thought, “Maybe she is after all not such a bad doctor as I made out?” But Hanna’s emotional state was still showing signs, so she said something completely different out loud and in a rather loud and angry voice.

The doctor did not react in any way to Hanna’s aggression. Instead, she very kindly invited Hanna to sit down and tell what was happening and how she felt (Fig. 17).

Fig. 17

After Hanna’s invitation to the office, the doctor moved to the next step of the BUSTER protocol. The letter U (Use nonjudgmental listening) means “Use impartial hearing”.

Tidy clothes, open posture (not taking a defensive stance), matching voice with a friendly facial expression confirmed the doctor’s attitude towards helping Hanna.

An important component of active listening is a skill to catch the patient’s expressions (gestures, sighs) and associate them with the spoken words. Care and observation is required here to track whether the information is true or not. Remember that it is not about you, but about other people’s disappointments, fears, anxieties that underlie anger.

Paying attention to problems of patient convenience (invitation to sit on a chair from the end of the table to prevent a barrier in the form of a table), maintaining eye contact significantly improves the consequences of emotionally difficult conversation.

It is also important to pay attention to the position of the body, the tone of the patient’s voice, keep own emotions under control during the communication.

During Hanna’s first answers, the doctor had a chance to engage the second step of the BUSTER protocol, which is called “Rule of six seconds” and corresponds to the second letter in the name of the protocol, the letter S stands for “Six second rule”.

This step serves to increase the level of the emotional balance. The doctor counted to 6.

It seemed to Hanna that the doctor sympathized with her very much and was trying to find out some other important detail about her well-being that would help to take the right steps for treatment. Therefore, Hanna decided to calm down and tell more details about everything that is happening to her (Fig. 18).

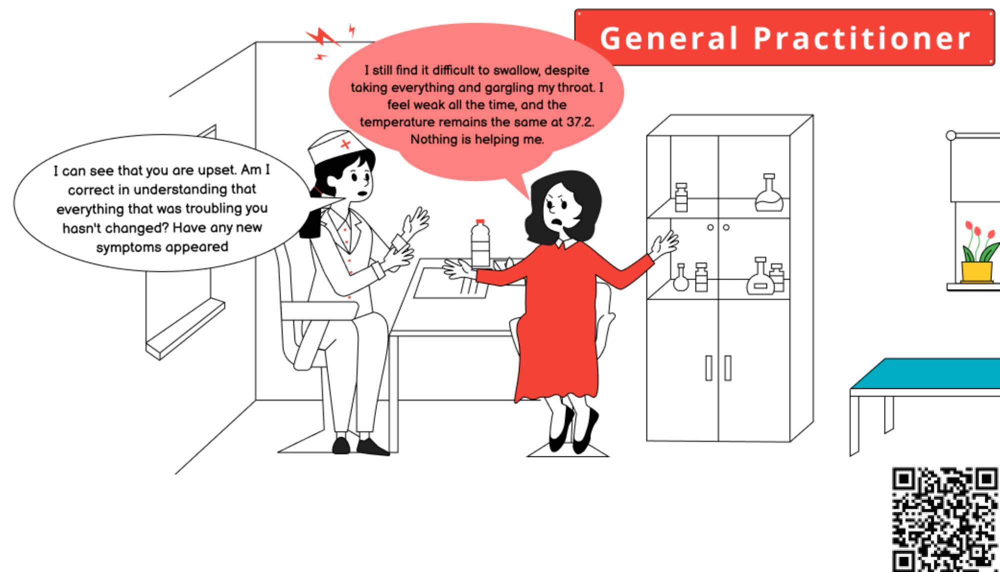


Fig. 18

The doctor is very professional, through showing empathy, unobtrusive demonstration of competence and a complete lack of condemnation of the patient for her aggressive behaviour, managed to turn the confrontation that started to develop in the first minutes of the consultation into a constructive conversation.

So, the doctor proceeded to the next two steps of the BUSTER protocol, "Tell me more" (the letter T — Tell me more) and "Empathize and validate" (letter E — Empathize and validate).

!!!	Effectively built relationships make it possible to set priorities.

As you can see, the doctor's not jumping to conclusions. He analyses the symptoms, asks for the patient's consent to the examination, receives feedback from the patient, explaining the sequence of his actions. The patient, listening to the calm voice and breathing of the doctor, becomes less tense, and this can be seen in her posture, she sits more comfortably in the chair, shoulders down, hands resting on her knees with palms down, she remembers how everything happened. The patient observes the doctor's confident demeanour, she believes that the doctor is a competent professional who can be trusted.

She said that nothing had changed in her health, her temperature remained at the same subfebrile level, and the treatment did not help her. In the course of the story, the doctor clarified some points several times. And when the doctor asked Hanna if she had any new complaints or sensations, Hanna realised that the doctor was very attentive to her, which made Hanna sure that she had not made a mistake in choosing her family doctor.

So Hanna immediately remembered that in the last few days, when she went to bed, the unpleasant sensation of a very frequent heartbeat had been added to her main complaints (Fig. 19).

Fig. 19

The third useful digression

While performing steps T and E of the BUSTER protocol, the doctor also used the technique of Norwegian psychologist Nils Grenstad known as the "Three-Step Rocket". This technique integrates the core skills of communication and greatly enhances its effectiveness. Nils Grenstad developed this method based on Arthur Jung's theory of cognition. Those who are deeply interested in theoretical psychology can study this theory separately. However, we are interested in the behaviour of the doctor who treated Anna, so we will elaborate on the essence of the "Three-Step Rocket".

The method helps you learn to respond to the obvious, to be concise and specific in your responses, to find the right words to encourage the patient to share the experiences openly and fully. The technique teaches you to be aware and express your feelings, which helps to be present during the consultation and builds trust in the doctor from the patient's side. The technique also makes it possible to always stay "here and now", in the present moment, without being distracted by unimportant events.

The doctor's choice in favour of this technique has been very successful, facilitating the establishment of a concrete and effective relationship with Anna. What is the essence of the method?

At the first stage the doctor meets the patient. He sees, hears, smells and thus encounters an obviousness.

At the second stage the doctor reacts and projects his experiences onto the patient, paraphrasing words and

clarifying the relationship between words and gestures in response to what he sees, using phrases such as "Do I understand you correctly..." and "I assume...".

At the third stage the doctor provides a personal response, "I want to clarify" (see Table 1).

Table 1

A three-stage rocket

The first stage: doctor ("I") meets with the patient Patient (stimulus)	*I, the observer, perceive the object, that is, I see, I hear, I feel, I smell, and because of this, I encounter with an obviousness which responds verbally and non-verbally: "I see tears when you talk about that. You talk about this". "I see that you are tired". "I can see that you're upset".*
The second stage: from the fact that I observe and perceive. I'm projecting my anxiety about the patient	*I use technology of paraphrasing "I project" — "I think", "I suppose", etc., "I understood you correctly, that everything that was bothering you has not changed at all?"*
The third stage: the doctor ("I") gives a personal answer, that is he notes like this experience echoes in him	*The doctor gives a personal answer, that is, noting how the experience echoes in him: "Was anything else added?" "What medication did you take under conditions like this?" "How long ago did these symptoms appear?" "I want to ask you what events it was connected with?" "I'd like to prescribe a lab test or ultrasound."*

After talking to the doctor, Hanna agreed to the second examination. The doctor carried out a full examination again. She commented on all her actions and explained the results. Hanna was now calm. Her confidence began to return that this is the place where she would get help (Fig. 20).

Fig. 20

When the examination finished, the doctor invited Hanna to sit next to her and hinted that the conversation would be serious. Hanna became anxious again as she realised that something was wrong. She continued to stand. Her appearance demonstrated that these words of the doctor had partly provoked the tension to return.

When the doctor told Hanna that she did not exclude a possibility that there was another disease hiding under the mask of acute respiratory infection and it was possible that the diagnosis could be changed, Hanna felt furious again.

Hanna started to blame the doctor in anger, “So you misdiagnosed me after all! It’s even worse than I thought!” (Fig. 21).

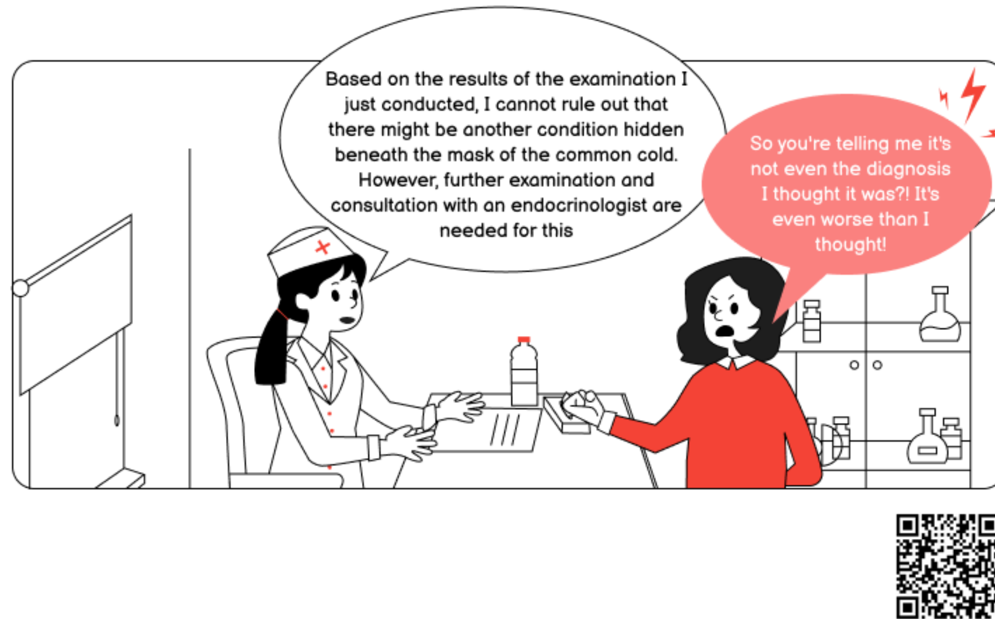


Fig. 21

However, the doctor remained calm, her friendly smile never left her face. In addition, the doctor insisted on the need for additional examination and consultation with an endocrinologist.

Professional and confident communication allowed the doctor to take control of the communication and turn it into a constructive one. The doctor was able to regain the patient’s trust and obtain permission for a follow-up examination.

With the words “I have an important conversation to have with you”, the doctor moved on to the final stage of the BUSTER protocol — the letter R means “Completion of Consultations and Recommendations” (“Respond with a wish statement”).

At this stage, in this case, it is crucial for the doctor to maintain interested eye contact, so that a friendly eye expression is combined with the voice intonation. The justification of the conclusion must be grounded. A particular attention should be paid to the patient’s verbal and non-verbal cues. This is very important, because the patient does not always express his thoughts directly and openly, so the doctor must catch and clarify the feelings and fears of the patient. The main goal at this stage is to reach full agreement with the patient.

We can see that the leading reaction of the patient in this situation is anger.

Therefore, the most appropriate decision for the doctor is to use the CONES protocol.

The doctor persistently invited Hanna to sit next to her and expressed sympathy for her feelings. The patient was still irritated, but the anger had passed (Fig. 22).

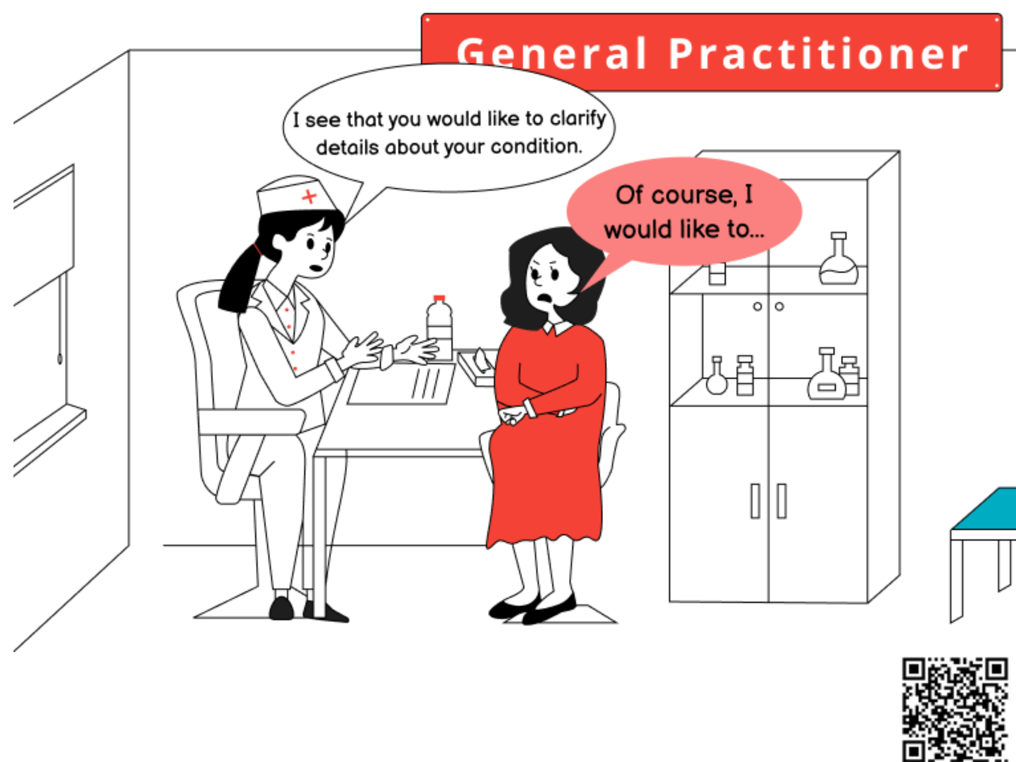


Рис. 22

The doctor confidently said that she wants and can help Hanna. That her condition indicates a complication of some other disease, which, in the absence of test results at the time of the first visit, she could not suspect.

!!! The CONES protocol is used in case of medical errors, deterioration of the patient’s condition, and in conversation with relatives of the deceased.

It consists of several stages:

1. Context — Organising the space and conditions for communication.

2. Opening short — Gaining permission to discuss. Explanation of facts.

3. Narrative approach — Chronology.

4. Emotions — Empathic response.

5. Strategy — Choosing a specific plan of action.

In our case, the letter C of the protocol is not relevant, as the space for conversation has already been created and the doctor is actively using communication skills to have a constructive conversation. Therefore, the doctor goes straight to letter O.

To do this, he invites the patient to sit down to communicate the change in diagnosis.

Maintaining eye contact, in a calm tone, non-verbally shows that the doctor is ready to talk and is responsible for her actions.

The doctor’s posture is open.

The feet firmly on the floor, no stiffness in movements, right hand pointing towards the patient.

!!!	Under any conditions, the doctor must have all his own emotions under control and not take a defensive position.

The doctor allows the patient to understand the news.

Draws attention to non-verbal signs (face, tone, gestures, posture) to assess the patient's emotional state.

Accepts the patient's point of view and his right to be disappointed with the treatment.

!!!	The focus of the doctor's attention should always be on the patient.

The doctor then decides that the patient is ready to give important news. The doctor's message itself is made clear, categorised and labelled with the intentions of warning the patient that all is not well).

The letters N — Narrative Approach (Chronology) and E — Emotion (Empathic Response) have already been realised by the doctor when using the Three Stage Rocket technique.

At the first stage, the therapist met Hanna and after seeing her mood, outlined the situation with the phrase "I can see how upset you are..."

At the second stage, in the process of observing and perceiving the patient, the doctor projected his anxiety onto her using the paraphrasing technique, "...I understand you correctly? ...do you have any concerns?"

At the third stage, the doctor gave a personal response, clearly noting how the experience resonated with her, "...I am willing and able to help you solve your problem. Your condition indicates a complication of some other condition that, due to the lack of test results at the time of your first visit, I could not suspect."

In further phrases, "To clarify the situation, I recommend that you undergo... Would you agree to have this done soon?" the doctor gave the patient an opportunity to express her fears and doubts.

!!!	Providing the patient an opportunity to express his fears and doubts is essential to creating an effective therapeutic alliance.

Hanna remembered that she did not give tests after the previous visit to the doctor and realised that the doctor could not be blamed for the mistake — the lack of tests and the delayed visit for several days did not give the doctor an opportunity to recognise another disease in time. It was Hanna's fault, but the doctor had never hinted at it.

The fourth useful digression

The doctor must know the patient's position otherwise unexpressed emotions can create or prolong conflict. As a result, the patient cannot receive the timely care and the doctor can feel uncomfortable that did not get in touch with the patient.

The doctor notes that the patient is angry, but behind these manifestations lies anxiety. When showing empathy, the emphasis should be on finding out how the error occurred. Excuses and blaming the patient should be avoided. All facts should be explained in such a way that the patient fully understands them. Information should be presented in a measured manner, with constant checking of the patient's understanding after each piece of information.

Therefore, when the doctor asked Hanna if she would agree to undergo the examination as soon as possible, Hanna immediately agreed and promised to have everything done the very next day.

At the end of the conversation, the doctor suggested to Hanna that once she had received the results of the examination, a clear plan for further action and treatment should be created (Fig. 23).

Fig. 23

The doctor also asked Hanna if she understood everything and if she agreed with the doctor's proposal. Hanna understood everything the doctor had told her and also realised that she was the only one who could fight for her health. And the doctor could only help her find the right path. So Hanna left the doctor completely satisfied and ready for the examination (Fig. 24).

Fig. 24

The letter S — Strategy.

The final stage of the CONES protocol requires the doctor to choose a specific plan of action. At this stage, it is important to summarise and discuss everything clearly and concisely with the patient.

As in the previous step, it is important to make sure that the patient has understood everything correctly.

A back-up plan should be drawn up.

!!!	Making a plan is the most important step in completing a consultation.

Explain to the patient what to do if something goes wrong. Explain that the patient can contact the doctor by telephone or go to the emergency department.

The doctor should speak in a calm, firm voice, demonstrating integrity and responsibility while maintaining emotional contact and agreement with the patient. It is important to get feedback on examination management in the form of agreement, nodding, posture and repeating doctor's words.

5.3. A Verdict is not a Verdict. The Wonders of the SPIKES Protocol

After visiting the doctor again and realising her own mistakes in her attitude towards her disease and the importance of following all the doctor's orders (especially those concerning additional examinations), Hanna took a more responsible approach to the examination plan. A few days later, they obtained the results. The doctor immediately told Hanna that all her symptoms were not a manifestation of acute respiratory viral infections, as they had thought at first, but were consequences of the thyroid disease — nodular goitre, against the background of which the level of hormones had significantly increased and hyperthyroidism had developed. It was the increased level of the thyroid hormones that caused most of the symptoms that were bothering Hanna. The doctor referred Hanna to her colleague, an endocrinologist, who prescribed the patient a puncture of the largest thyroid nodule and a follow-up visit after the histological results are obtained.

Since at this stage Hanna's mood and the doctors' professionalism were focused on getting the result, nothing interesting happened from the point of view of the psychology of communication. Therefore, let's not dwell on these stages, but move on to the next appointment with the endocrinologist, where Hanna heard her "verdict", on which all further behaviour of our heroine, her mood, her desire to fight and defeat the disease depended.

As you have already guessed, not very good news waited for Hanna, so the doctor had to choose the protocol of behaviour that would help the patient to avoid stress and psyche her up to fight the disease. In this case, the "gold standard" in the world is the SPIKES protocol. This protocol is used when breaking bad news and requires the highest professional skills from the doctor: mastery of words and gestures, the ability to support the patient and show empathy in a difficult moment. The doctor must sensitively and delicately involve the patient in the process of interaction, to go through with him a complex path of understanding and acceptance of the disease. Let us understand this extremely complex protocol in detail.

The endocrinologist created the friendliest environment: he moved a comfortable chair instead of a stool to the patient, prepared a glass, a bottle of water and napkins (in case Hanna could not hold back her tears). When Hanna entered the office, the doctor said, "Good afternoon, Hanna, please have a seat! How are you?", looked at her intently and gestured for her to sit at the table, closer to him. It was obvious that Hanna was very anxious, even afraid to hear the results of the examination. She replied that her condition had not changed since her last visit to the family doctor (Fig. 25).

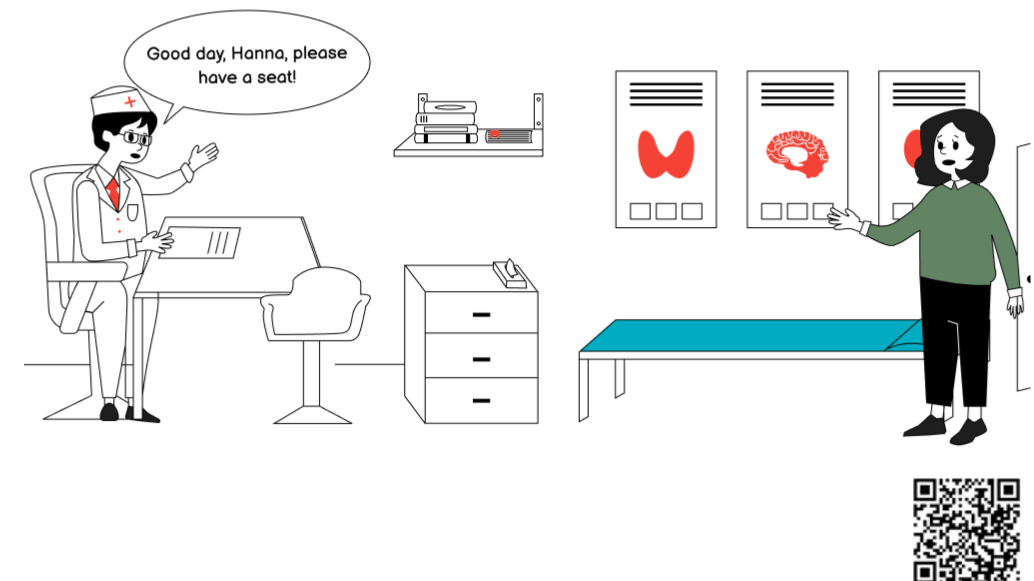


Fig. 25

When Hanna came to the endocrinologist, she was very nervous because she realised that the biopsy would not be taken for nothing and that she could be in for some very bad news. She was staying outside the door for a long time, not daring to enter, and even the phrase "You're going to die soon..." sounded in her head. But the doctor's demeanour and a very comfortable chair at his desk hinted to Hanna that things could still be good. Hanna calmed down a little and tuned in to the conversation.

The doctor said that he had allotted about half an hour to talk to Hanna and felt that this would be enough time to resolve all the issues. Hanna remembered well that all previous visits to doctors lasted less time, so she mentally agreed with the doctor. However, she clearly understood that the doctor was very busy and if he had allocated so much time for her, he should not waste it on meaningless conversations and complaints about life, but she could not resist asking if she was dying (Fig. 26).

Рис. 26

The first step of the SPIKES protocol is to organise a space for communication. The letter S (SETTING UP the interview) means "Organization of the interview".

We have already described the preparation of the office environment and the appearance of the doctor. These requirements do not change in any way when using the SPIKES protocol.

However, there are some peculiarities in the doctor's behaviour. First of all, there are certain non-verbal signs of the doctor's attitude towards the patient. These include:

— inviting the patient to sit at the end of the table so that the table is not an obstacle (in this case, relatives or accompanying persons whom the patient would like to invite to the interview may sit a little far distance);

— eye contact is necessary;

— a voice, rate of speech, intonation and facial expressions that demonstrate kindness and empathy;

— appropriate posture, open pose and gestures

It is also important to make sure that nothing distracts from a difficult conversation before the conversation begins:

— the mobile phone should be on a silent mode or switched off;

— filling out documentation during the conversation should not interfere with dialogue and mutual understanding.

The doctor invited Hanna to talk about how she understands her condition. This is a very good conversation starter in the SPIKES protocol. Hanna immediately felt that the doctor was willing to help her. Hanna's frank answer helped the doctor to correctly assess her initial point of view and feelings, which is especially important when the patient is frightened (Fig. 27).

Fig. 27

The doctor was able to choose the right non-verbal symbols to reassure Hanna: he leaned closer and touched her hand that was lying on the table. Hanna did not object, she actually felt some relief.

When the doctor asked Hanna how she understood her condition, citing that she wanted to fully understand the issue, the only thing Hanna was able to answer was that she was very scared and afraid of dying.

The doctor asked Hanna to elaborate on her thoughts and feelings about her disease. At the same time, when Hanna's voice trembled and she was ready to burst into tears, the doctor moved a little closer to her and gently touched her hand. This had a calming effect on Hanna.

Throughout the dialogue, from the very beginning, the patient's view of the situation should never be judged. On the contrary, the situation requires empathy to express understanding and respect for the patient's feelings.

Throughout the conversation, it is important to pick up on the patient's non-verbal cues (body language, speech, facial expressions, emotions), respond to them, verify that your sense of the patient's emotions is correct, and express understanding.

Having created all the conditions for a frank conversation, the doctor moves on to the next step of the SPIKES protocol, which is labelled P (Assessing the Patient's PERCEPTION) and means "Assessing the Patient's Understanding of the Seriousness of his Condition".

It is important to ask what the patient is thinking and feeling and to clarify this in order to continue the trusting conversation.

It is important to pay attention to the patient's reaction, not just what he tells. In such cases, it is important to avoid prematurely giving information, explanations or advice without consulting the patient.

The doctor's actions should help the patient to communicate his assumptions, his fear of death (if it does exist). In response, the doctor should demonstrate understanding of the patient's difficulties through empathic non-verbal communication (facial expressions, proximity, touch, tone of voice or silence).

The doctor said he could see the excitement and strong emotions that Hanna was having trouble dealing with. When Hanna told about her feeling sick, she bowed her head and sighed.

The communication the doctor was having was not quite familiar to Hanna, it was different from what had happened at previous doctor's visits. But the doctor's attitude and his ability to sense Hanna's inner state did their part: Hanna was no longer nervous, fully prepared to face any news constructively (Fig. 28).

Fig. 28

When the doctor saw that Hanna was ready to get information about her disease, he asked her if he should tell her the results in detail or briefly talk about them and discuss the treatment plan. Hanna felt that there was no more fear, she was ready to fight for herself. She raised her head, looked into the doctor's eyes and told him that she wanted to know all the information.

The next step of the SPIKES protocol is intended to help the doctor take communication with the patient to the level where it's most effective. the most effective. This step is labelled with the letter I and is called "receiving the patient's invitation"). The guiding rule for this step is as follows "Ask before you speak".

The doctor used "Three-Step Rocket" technique which you are already familiar with: first he showed his attention to Anna, "I can see your excitement"; then the doctor expressed his sympathy, "...these are very strong emotions, it's hard to deal with"; after all the doctor asked how much information the patient was ready for, "It's good that you told me about them". (pause) "Are you ready to take full information about the results of the examination or do you want to note the results and discuss the treatment plan in brief?"

Using the "Three-Step Rocket method", the doctor was sensitive, understanding of strong emotions, and giving countenance. Clarifying the patient's awareness prior to the consultation and ascertaining her desire for information helped the doctor to make further communication. So, at this stage of the protocol, by asking the patient if she wanted to know details about her health and treatment, the doctor clearly articulated the goals and form of further conversation.

When Hanna demonstrated a willingness to reflectively listen to any news about herself, the doctor informed her that the news would be bad because histologic examination revealed malignant cells. Despite Hanna being ready for bad news, she was unable to hold back her tears (Fig. 29).

Fig. 29

The doctor explained clearly and in ordinary words (without special terms that Anna did not understand) what was happening to her body and the thyroid gland. He talked about possible factors that could have triggered the disease. Hanna even felt that now she knew everything she needed to know about herself so that she would not give in to the fear that always appeared in her when she did not understand something and did not know how to deal with it.

After preparation, the doctor and patient were fully ready to the fourth step of the SPIKES protocol, which is labelled with the letter K and means “Giving KNOWLEDGE and Information to the Patient”.

The following features of the conversation are very important at this stage:

— don’t take too long, but also don’t give the patient too much information at once;

— watch the pace of the story and the pace of the patient’s understanding;

— choose words carefully, taking into account the patient’s reactions and emotions;

— constantly monitor the patient’s nonverbal expressions, notice them and respond immediately;

— allow periods of “rest” — times when the patient stops listening;

— allow for objections;

— take breaks.

In Hanna’s case, the doctor always noticed the patient’s nonverbal expressions, let her know that the news would be difficult, and made a pause. The doctor was engaging and interrupted the silence when the patient was ready to continue talking. This phase of the protocol also requires the doctor to help the patient focusing on the fact that there are options for prolonging life, and that these can and should be discussed (Fig. 30).

Fig. 30

When Hanna entered the office, the doctor saw that she was accompanied by a man who remained in the hall. Therefore, to further maintain Hanna's stable psychological state and prevent the development of stress, the doctor offered to invite him into the office if it could help Hanna with a difficult conversation. Hanna happily agreed (Fig. 31).

Fig. 31

Hanna's husband was also very concerned and nervous. But the doctor's calm tone and Hanna's almost calm demeanour did their job. So the man also quickly set up himself for a constructive conversation (Fig. 32).

Рис. 32

The doctor moved on to the next step of the SPIKES protocol by suggesting that someone close to Hanna be invited to join the conversation. The fifth step of the protocol is labelled with the letter E, which means "Addressing the Patient's EMOTIONS with Empathic Responses".

So, the doctor supports the patient by making her feel that she is not alone. In this way, the doctoremphasised his intentions to cooperate with Hanna, showed attention to her experiences and fears, and demonstrated his care. At this stage, the doctor should be able to express empathy through voice, rate of speech, or silence (depending on the patient's condition and reactions). The doctor should express his competent opinion and never demean the patient or pressure the patient with his authority. If the patient tries to avoid the conversation, the doctor must understand his thoughts. And to restore the conversation in this situation will help additional respect for the patient's personality and encourage him to ask questions.

The doctor should let the patient know that he is ready to cooperate with him, to discuss different treatment options and to support him regardless of the choice of treatment. In Hanna's case, the doctor did not forget that discussing treatment can distress the patient, so, sensing her discomfort, he listened to her and invited her husband into the conversation (Fig. 33a, b).

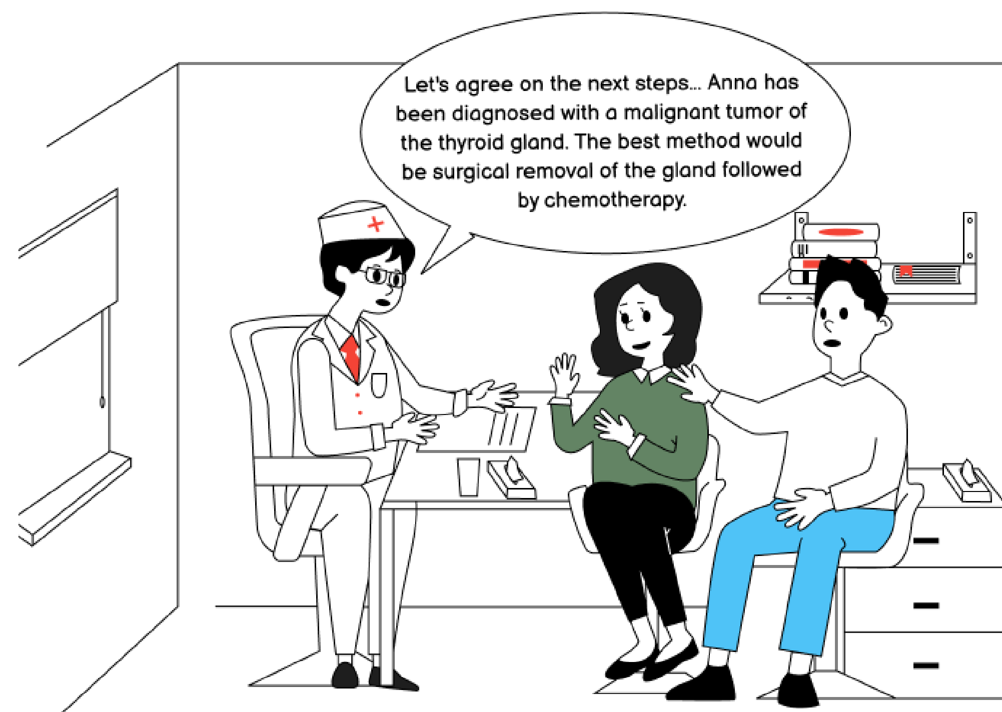


Fig. 33a

Fig. 33b

The conversation was very difficult for Hanna. She was very worried that she would not be able to understand something, that her condition was hopeless, that the doctor would not talk to her and answer her questions. But already from the first minutes of communication she felt and realised that she was in safe hands, who could really do everything possible for her recovery.

And although she heard a terrible diagnosis, which she feared more than anything else in the world, the doctor was able to explain everything to her so clearly and tell her about all possible variants of the course of the disease, the severity of which largely depends on the patient's mood. So, Hanna realised that her health was in her own hands and in the hands of the doctor, whom she trusted completely after the conversation.

She knew she had a complicated way to recover but was confident that with the doctor's help she would be able to overcome everything. The doctor told Hanna in great detail about all the peculiarities of the surgery, the positive and side effects of chemotherapy, life after the surgery and the course of treatment, as well as about all possible complications and the possibility of treatment failure. This gave Hanna confidence that she was not being deceived, that the real state of affairs was not being embellished.

This mindset helped Hanna overcome everything that lay ahead. Even the negative conversations with some of the medical professionals she encountered during treatment. The confidence in her recovery during making the diagnosis that the endocrinologist instilled in Hanna helped her to ignore everything that happened afterwards.

That's why, when we met at the party, Hanna was the life of the party and brought a lot of positive emotions to everyone.

After explaining everything that was going on with Hanna to her husband, the doctor moved on to the last, sixth step of the SPIKES protocol, which is labelled S and is called "Explanation and Planning. Completion of Counseling" (STRATEGY and SUMMARY).

At this stage, the doctor should realise that his authority is limited and the treatment process depends on many factors. It is important to refrain from making promises of recovery. An important part of this step is the opportunity for the doctor to tell his feelings and to see their acceptance by the patient, to convey empathy and the patient's desire to live and be with close ones.

By taking the time to clarify the expectations of Hanna's husband, the doctor focused on her health condition, her feelings, and did his best to engage Hanna during treatment, to evoke hope for continued life. It also became important to prioritise what could be fixed and what could not, and to pay attention to quality of life during and after treatment.

At this stage of counselling, the doctor should avoid long monologues. It is required:

— clearly provide important information about the procedures or surgeries and possible sensations;

— explain in clear words why it is necessary;

— encourage the patient to ask questions;

— discuss the possibility of a negative outcome.

It was also important how the doctor reacted to Hanna's distress. He gave her time to think and accepted the patient's opinion without judging it. As a result, the patient became more involved in the treatment discussion, which led to greater satisfaction with the consultation for both doctor and patient, and was key not only to a further relationship of trust but also to Hanna's practical recovery (Fig. 34).

Fig. 34

INSTEAD OF AN EPILOGUE

We are very happy that Hanna was able to overcome the disease. She has been in complete remission for more than three years now, and the endocrinologist has become one of the best friends for her and her husband.

Hanna is also in frequent contact with Anastasia Ivanivna, who referred her to the endocrinologist in time, and is very grateful to her for her patience and professionalism.

We hope that Hanna's story has demonstrated how important communication with a doctor can be for a patient's future life, especially in complicated cases. We decided to devote the second part of the tutorial to looking at Hanna's negative experiences with medical professionals and we have fantasised a bit about possible scenarios for Hanna if doctors had behaved differently.

CHAPTER 6

PSYCHOLOGICAL CHARACTERISTICS OF THE PATIENT

During physical illness, the psychological state of a person can undergo various changes and have certain features. This concerns all the spheres: emotional, social, behavioral, thoughts, aggravation of certain character traits. In this section we will list some of them.

Emotional reaction. People often experience fear, anxiety, sadness, and other negative emotions associated with illness. They may feel a loss of control over their lives and feel vulnerable.

Stress. Physical illness can be a source of great stress. People may worry about the incomprehensibility of the diagnosis, possible consequences of the illness, complications in the treatment process, etc.

Body perception. Changes in the body due to the disease or treatment can affect the perception of one's own body. This can cause feelings of dissatisfaction with one's own appearance and reduced self-esteem.

Social isolation. The disease can lead to physical limitations and the need for rest. This can affect social relationships and cause feelings of alienation and isolation.

Relationships with other people. The disease can affect relationships with close people. Some people may feel supported and understood, while others may experience misunderstanding and miscommunication.

Depression and anxiety. Physical illness can be a risk factor for depression and anxiety disorders. Sometimes this is due to physiologic changes in the brain caused by the disease.

Acceptance. Over time, people can come to terms with their disease and find ways to live fulfilling lives despite physical limitations.

Post-traumatic growth. Some people may find positive aspects to their experience of the disease, such as improved self-awareness, greater appreciation for life, deeper understanding of others, and so on.

It is important to emphasise that the reaction to the disease is individual and depends on many factors, such as the person's previous psychological characteristics, the support of the environment, the type of illness, the severity of symptoms and many others. Sometimes professional psychological support can be helpful in accepting and adapting to the new reality, helping to cope with the emotional difficulties associated with the disease.

At the beginning of the consultation, the doctor has the difficult task of capturing the patient's verbal and non-verbal cues to lay the foundation for a trusting relationship, determine the patient's psychological type, understand what reactions to expect and what protocol to follow in communication. The psychological types of patients can be studied from different points of views, depending on the approach to psychology and medical practice. The psychological characteristics of the patient can also vary depending on the nature of the illness and the individual characteristics of the patient. However, some common features can be emphasised.

Emotional reactivity. Some patients may tend to have strong emotional reactions to their health condition. This can manifest as increased anxiety, depression, panic attacks, and so on.

Ability to cooperate. Some patients may be more inclined to follow medical advice, adhere to a regimen and treatment. Others may be less cooperative and refuse to take necessary actions.

Vulnerability to stress. The disease may increase a patient's vulnerability to stress and negative events. This can lead to a worsening of psychological distress and exacerbation of symptoms.

Coping strategies. Each person has different ways of coping with stress and difficult situations. Some patients may seek support from family and friends, while others may feel the urge to withdraw from reality.

Information perception. Patients may perceive information about their health in different ways. Some may seek a lot of information and reflect on it, while others avoid detailed information.

Self-identification with the disease. Some patients may put their disease at the centre of their personality and identify with it. This can affect their self-esteem and sense of self-worth.

Perception of control. Some people may feel unable to control their health and the situation around them. This can lead to feelings of helplessness and fear.

Support and social isolation. Patients may seek support from family, friends and healthcare professionals, but may also experience social isolation due to their disease.

It is important to recognize that each person is unique and approaches to working with patients should be individual, based on mutual understanding and cooperation. A personal approach takes into account the psychological characteristics of each individual patient, helping to create a more effective treatment and support plan.

Psychologists and psychiatrists use different classifications of patients' psychological types to better understand their characteristics and choose the most effective treatment methods. However, it is important to realise that each individual is unique, and classifications can be simplistic or imperfect.

Here are some popular psychological types of patients.

Types by reaction to stress:

Type A. Individuals who tend to lead competitive and overly stressful lifestyles and are often characterised by intense working, impatience, and increased vulnerability to stress.

Type B. People who avoid interaction and are "withdrawn". They sometimes appear "calm", avoiding conflict and saying they don't need anything. Often these people are more traumatised and need help.

Types by personal traits:

Extroverts. People who are energetically oriented, sociable, and seek out new experiences in the environment.

Introverts. People who are more inward-oriented, tend to feel loneliness and are less dependent on external stimuli.

For better understanding, we also find it useful to provide in Table 2 the classification of major personality disorders according to the International Classification of Diseases, 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). According to these classifications, different types of mental disorders are distinguished.

Table 2

International Classification of Diseases, 10th Revision (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)

ICD-10	DSM-5
	Cluster A
Paranoid (F60.0)	Paranoid
Schizoid (F60.1)	Schizoid
	Schizotypal
	Cluster B
Dissocial (F60.2)	Antisocial
Emotionally unstable (F60.3): • Impulsive type (60.30) • Boundary type (F60.31)	Boundary
Hysterical (F60.4)	Hysterical
Other specific personality disorders (F60.8) • Eccentric • Uninhibited • Immature • Narcissistic • Passive-aggressive • Psychoneurotic	Narcissistic
	Cluster C
Alarming (F60.6)	Avoidant
Dependent (F60.7)	Dependent
Anankastic (F60.5)	Obsessive-compulsive

According to the DSM-5, there are three clusters: Cluster A, Cluster B, and Cluster C.

Cluster A (paranoid, schizoid, schizotypal). Personality disorders that are collectively referred to as "bizarre or eccentric disorders". Common features of disorders in this cluster include social awkwardness and withdrawal, as well as distorted thinking.

Cluster B (dramatic, emotional, or erratic disorders) includes antisocial, borderline, histrionic, and narcissistic personality disorders. Common characteristics of these disorders are problems with self-control (impulsivity) and emotional regulation.

Cluster C (avoidant, dependent, and obsessive-compulsive personality disorders) is known as "anxiety and fear disorders". A common feature of disorders in this cluster is a high level of anxiety.

Psychological types can also be distinguished by their style of perceiving information.

Sensory types are focused on concrete facts, details and realism.

Intuitive types prefer general impressions, tend toward abstract thinking and deep contemplation.

Types differ in their methods of conflict resolution.

Aggressive: People who express their needs and opinions through aggression and conflict.

Passive: People who avoid conflict, do not express their needs, and often agree with everything.

Assertive: People who express their needs openly and without aggression while maintaining respect for others.

Types are also distinguished by their reaction to changes.

Resistant: People who avoid changes, feel stressed by new situations.

Adaptive: Individuals who quickly adapt to changes and can handle new tasks.

These are general classifications, each person may have a combination of different characteristics that may only manifest themselves due to certain circumstances triggered by the disease, communication style or previous experiences. Therefore, it is important for the doctor to know the individual characteristics of each person in order to provide effective care and treatment.

To make the doctor-patient relationship more visible, let's try to use the dichotomy of notions "awareness" and "freedom" proposed by Canadian psychotherapist Karl Tomm, professor of psychiatry at the University of Calgary Faculty of Medicine. Dichotomy is a division of the whole into two parts that are collectively comprehensive and mutually exclusive (any component must necessarily belong to one of the parts, and at the same time no component can belong to both parts at the same time).

The author used the term "awareness" to explain the changes that occur to the patient during the consultation, and the term "freedom" to explain the patient's choice of behaviour during the consultation. We are interested in how a particular physician's stance affects the patient.

For convenience and clarity, we have developed a "Therapeutic Interaction" diagram. The types of interactions presented in the diagram demonstrate the intersection of physician and patient positions, which are organised into four quadrants that describe four types of therapeutic relationships between doctor and patient (Fig. 35).

Types of therapeutic interaction

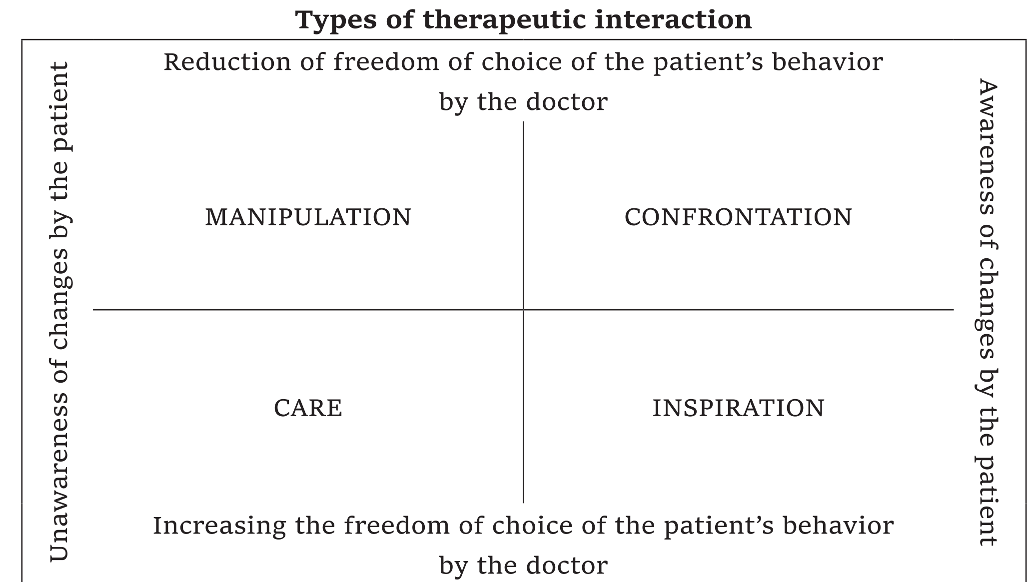


Рис. 35

The left vertical reflects the patient's attitude to his health, possibly including unwillingness to keep a healthy lifestyle (work and rest regime, adequate sleep, physical activity, balanced diet, self-control), as well as unconscious, inadequate perception of symptoms. Patients may be uncritical of their condition and exaggerate the severity of the disease.

The right vertical represents patients who notice painful symptoms, recognize that changes are occurring in their body for various reasons, and do not avoid discussing their condition. They are able to make connections to various events that may have affected their health and are ready to interact with the physician to improve their quality of life.

The upper horizontal reflects the physician's attitude toward his work, including an inability or unwillingness to build partnerships. The doctor does not use non-verbal skills to build trust, does not engage the patient in dialog, does not ask about the patient's feelings and

expectations, and does not consider discussing treatment modes with the patient in an accessible and understandable way.

Lower horizontal: The doctor uses verbal and non-verbal skills to establish a trusting relationship with the patient. He listens respectfully without interrupting to gather important information about the illness in order to make an accurate diagnosis. The physician explains in clear language the cause and effect of symptoms and ways to cope with the disease. He can respond respectfully to what the patient says without being judgmental, showing that the patient is entitled to his opinions and feelings, which is necessary to understand his position on his health condition and needs. The doctor uses nonverbal communication skills to emphasise verbal messages about body sensations, recommended procedures, tests, and treatments, appreciating the patient's desire to actively participate in diagnosis and treatment. This is essential for the patient to responsibly follow instructions and get well.

These four spaces demonstrate different approaches to patient care:

Manipulation space. The patient does not receive clear information about the diagnosis, possible complications and side effects, treatment options, does not understand his role, cannot express his point of view, share his emotions and expectations. As a result, they do not follow the doctor's recommendations, resulting in poor health.

Confrontation space. The patient does not receive sufficient information about the diagnosis, possible complications and side effects, treatment options, can express their point of view, but does not receive emotional support and acceptance from the doctor. As a result, does not follow the doctor's recommendations, which leads to deterioration of health.

Care space. The patient receives sufficient and understandable information about the diagnosis, possible complications and side effects, treatment options, but does not understand his role, cannot express his point of view, share his emotions and expectations. As a result, does not understand his next steps and do not follow the doctor's recommendations, resulting in poor health.

Inspiration and growth space. The patient receives sufficient information about the diagnosis, possible complications and side effects, treatment options, can express his opinion, share his emotions and expectations, receive emotional support, accept his point of view,

discuss the optimal treatment plan and as a result follow the doctor's recommendations, which leads to recovery.

Let's consider how this situation could unfold, on example relationship between Hanna and Dr. Anastasia Ivanivna (Fig. 36–41).

Manipulation space

Рис. 36

In the picture, we see the doctor wearing a clean lab coat and sitting in a well-lightened, warm room. The doctor and the patient seat across from each other, with the table acting as a barrier to the partnership. The doctor greets the patient but does not address her concerns. The physician does not react emotionally. She clarified the patient's first and last name and asked how she preferred to be addressed. The doctor asked when she began suffering from headache and sore throat and if there were any other complaints.

In the first few minutes of communication, a first impression forms, which lays the grounds for further interaction. In this situation, the doctor listens inattentively to the patient's story and does not express sympathy. The doctor does not encourage the patient to engage in dialogue. She examines the patient and prescribes tests and treatment without making sure that Hanna understands. It is possible that the patient will not follow the doctor's recommendations and the disease may cause complications.

The space of confrontation

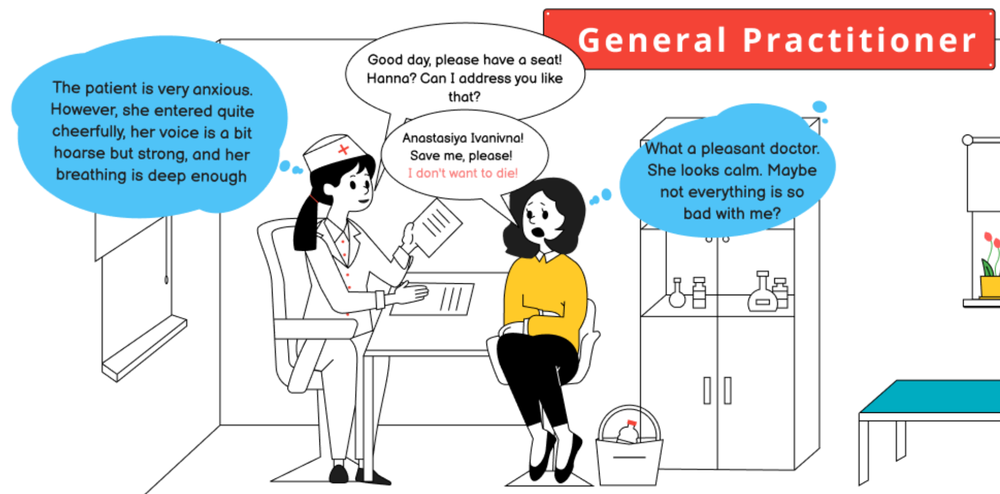


Fig. 37

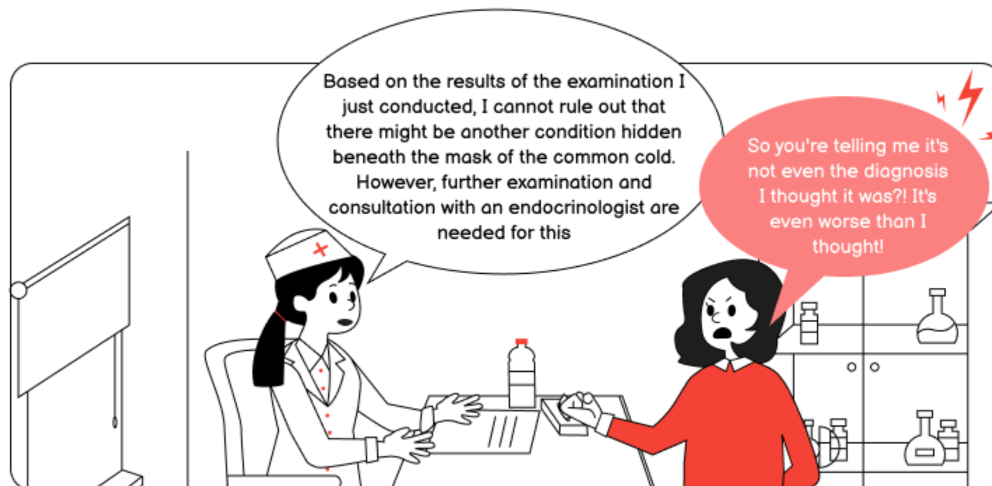


Fig. 38

The doctor and the patient are at an angle, but the doctor's back is reclined, which is not conducive to a partnership. The doctor greets the patient and notices that the woman is very frightened and is sitting in a tense posture. The doctor ignores the patient's anxiety and does not react emotionally. She clarifies the patient's first and last name and asks how she prefers to be addressed. The doctor then informs the patient that she needs to consult an endocrinologist without preparing the patient for the conversation. Thus, we see how the lack of emotional support leads to conflict. The doctor quickly moves to change the diagnosis, resulting in the patient showing anger. The patient changes her posture and sits directly across from the doctor, "defending" herself from the doctor's indifference.

This consultation is likely to end soon. This may result in a complaint about the doctor's incompetence, the patient's health deteriorating due to stress, and lost time.

The space of care

Fig. 39

Space of inspiration

Fig. 40

In the situation described, we see that the doctor has put aside previous things, looks kindly at the patient, maintains eye contact and has an open posture: the right hand is directed towards the patient, the palm is open and the torso is slightly bent forward, inviting conversation. The physician is dressed in a clean, ironed lab coat and makes initial contact. The physician greets the patient and notices that she is very frightened and sitting in a tense posture. Showing respect, the physician takes care of the patient's physical comfort (gives water and tissues). Such simple acts of courtesy encourage further communication.

The doctor then explains details of the treatment. However, the doctor does not tell the patient and her husband about the different treatment options, nor asks about their expectations and possible side effects, assuming that the patient and her husband are not ready to ask questions.

So, we have consequences for each option of the therapeutic interaction (Fig. 41).

Consequences of therapeutic interaction

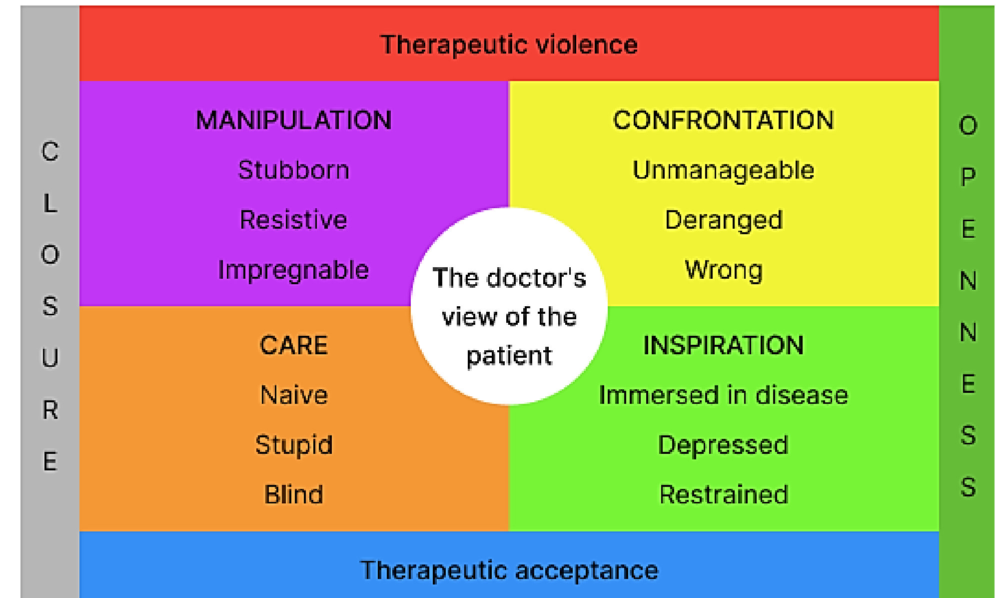


Fig. 41

The four spaces illustrated in the scheme demonstrate different approaches to patient care. To varying degrees, a doctor combines all four positions in his work. The proportions of their presence in medical practice may vary. If the doctor is aware of his role in the consultation, he works more effectively, demonstrating his professional and communication skills, reducing the number of conflict situations, and patients follow his recommendations more responsibly.

So, the ethical positions of the doctor form, which correspond to the described spaces and directions of possible work with the patient (Fig. 42).

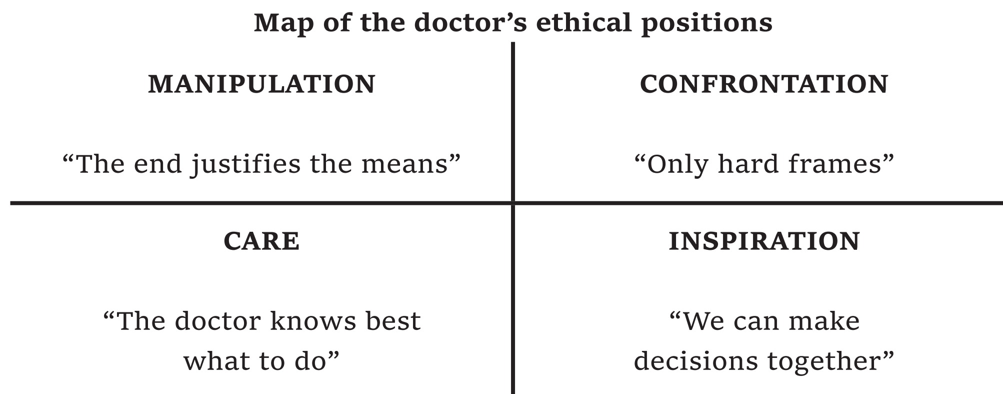


Fig. 42

As you have already noticed, expressing emotions and feelings is important for effective counselling. By showing emotions, it creates a "nurturing environment" for a trusting relationship. The disease makes the patient vulnerable, he is often afraid to talk about his fears, expectations and ask questions for fear of a patronising response from the doctor. So, a "wall of misunderstanding" grows between doctor and patient, depriving the patient of support and empathy. Moreover, the doctor who "hides" behind rationality and excessive equanimity deprives himself of the opportunity to share the joy of the consultation process. Emotions "touch the heart", make a person vulnerable, doubtful, but, on the other hand, they inspire hope and make you feel happy.

How to quickly and accurately identify all the psychological characteristics of a patient during the first few minutes of dialogue will be discussed in detail in our next textbook.

CHAPTER 7

PROBLEMS AND CHALLENGES IN COMMUNICATING WITH PATIENTS

Communication between a doctor and a patient is an important aspect of providing qualified medical care, but ineffective communication can arise due to various problems and challenges. Here are some of them.

Time constraints. Doctors often have limited time for each patient, which can block establishing effective communication.

Difficulty in explaining medical terms. A doctor must be able to explain complex medical information to patients in a way that they can understand and make appropriate decisions.

Emotional reaction of patients. Patients can be emotionally vulnerable in moments of fear, anxiety, or anger, and doctors must be able to effectively interact with these emotions.

Refusal of treatment. Some patients may refuse the doctor's recommendations or treatment, which can affect their condition and require additional persuasion and support.

Excessive or incorrect use of internet information. Patients may find medical information in the Internet that may be unreliable or incorrect, so doctors must be able to respond to questions and correct misunderstanding.

Cultural and language barriers. Doctors may deal with patients from different cultures who may require special attention to intercultural communication and translation.

Difficult conversations. Communicating about palliative care, poor prognosis, or other difficult topics can be a significant challenge for doctors and patients.

Lack of cooperation among doctors. In some cases, sharing information between different specialists is necessary, which can lead to communication problems.

Solving these problems requires skills in effective communication, empathy, and the ability to adapt the approach to the specific

needs of each patient. It is also important to develop listening and communication skills in teamwork with other healthcare professionals.

We believe that any issues of communication are more conveniently and effectively considered as specific examples. Therefore, in this section, we present situations in which the doctor may encounter difficulties.

7.1. The Suspicious Patient

A 60-year-old female patient suffering from severe diabetes is in the endocrinology department of the hospital. Due to complications from diabetes, her attending doctor invited a surgeon for a consultation. The consultation takes place in a special examination room at the department. The patient entered the room with a sceptical expression on her face. She addresses the doctor in an arrogant manner, with a firm, non-negotiable tone. Her movements are purposeful and energetic. The space in the examination room allows for the patient to be opposite the doctor with no barriers between them. The doctor set his phone to silent mode, greeted the patient, and demonstrated non-verbal active listening skills.

The following dialogue took place between the doctor and the patient:

Doctor: Good afternoon, Mrs. Maria! May I address you this way?

Mrs. Maria: Good afternoon. I am Maria Vasylivna.

Doctor: Please have a seat, Maria Vasylivna. My name is Ivan Ivanovych Ivaniv — I am a surgeon. I will be consulting you.

Mrs. Maria (distrustfully): Yes, my family doctor referred me to you.

Doctor: Mrs. Maria, please tell me what ails you?

Mrs. Maria (angrily): My leg ails me, nothing helps. I think the treatment was wrong!

Doctor: I really want to help you. Tell me what you are thinking right now, or shall I examine you afterwards?

Mrs. Maria (suspiciously): You are all in cahoots. (pause) Your treatment is only making things worse! My grandfather had diabetes, had gangrene, was treated incorrectly, and then he died. (pause)

The doctor non-verbally expresses sympathy. (pause)

Doctor: Mrs. Maria, can we continue our conversation?

Mrs. Maria nods.

Doctor: I have the results of your examination. Would you like to receive information about the results and discuss the treatment plan?

Mrs. Maria: Of course.

Doctor: Unfortunately, I have bad news for you; diabetes has caused severe complications, and you need surgery.

Mrs. Maria: Are you hiding anything from me?

Doctor: No, I am not hiding anything from you.

Mrs. Maria nods.

Лікар (sympathetically and affirmatively): Are you ready to discuss the surgery and treatment plan now? If you have any questions, I will answer them.

Mrs. Maria: Yes.

The doctor sees that the patient is behaving provocatively, with aggression and suspicion, expressed through both verbal and non-verbal cues. He understands that such behaviour hides fear, which commonly includes social awkwardness and distorted thinking.

The doctor behaves considerately, does not avoid answering questions. He conducts the dialogue with respect, informs her about confidentiality. With emotional tension, he verbalises his assumptions.

7.2. The Angry or Hostile Patient

A patient with a hand injury came to see the doctor. He was doing some minor repairs at home and accidentally hit his finger with a hammer. He wrapped his finger with a handkerchief and came to the clinic. The doctor greets the patient and demonstrates active listening skills.

Doctor: Good afternoon, Mr. Ivan. May I address you this way? Please, have a seat.

Mr. Ivan: Yes.

Doctor: Please, tell me what ails you.

Mr. Ivan: Doctor, my finger hurts. I accidentally hit it with a hammer. It hurts a lot, and look, it's swollen.

Doctor (puts on gloves): Allow me to examine you.

During the consultation, the doctor apologises and gets distracted by a conversation with a colleague about the morning surgery. The doctor sees that the patient is tense, with clenched jaws.

Mr. Ivan: I don't understand why I have to wait.

Doctor (demonstrates active listening skills): I'm sorry, Mr. Ivan. I appreciate you waiting for me. Thank you. Did I understand correctly that you hit your finger with a hammer during the repairs? May I remove the bandage and examine it?

Mr. Ivan (displeased): Yes. It hurts, be careful! I'm afraid it might be broken.

Doctor (examining the finger): I am prescribing an X-ray. I will explain in detail where you can have it done...

Mr. Ivan: I understand.

Doctor: I'll be waiting for you with the results. See you.

Mr. Ivan: Thank you.

The doctor hears a gruff voice, sees an angry face, and understands that the patient's finger hurts a lot. He apologises for making him wait, addresses him by name, repeats the patient's complaints, demonstrates attention, examines the finger, and prescribes X-ray. He does not engage in conflict, uses unbiased listening, and does not take a defensive stance.

7.3. The Anxious Patient

In the corridor, the doctor meets his patient who recently had a biopsy. He sees that she is confused and nervously fidgeting with a tissue in her hand. The patient speaks in a broken voice. The doctor demonstrates effective non-verbal actions.

Patient: Doctor, I wanted to ask about my diagnosis.

The doctor demonstrates active listening skills and invites the woman to the office or moves to a more comfortable place.

Doctor: Good afternoon, Ms. Olena. I hear the anxiety in your voice. I understand that you would like to know your diagnosis today, but we need to wait for the test results. We are meeting on September, 5 at 10:00. Is that convenient for you?

Patient: Yes.

Seeing that the patient looks worried, the doctor expresses support both verbally and non-verbally. He uses active listening and facilitation skills. He explains when the test results will be available. The woman calms down and agrees to come the next day.

7.4. The Hypochondriacal Patient

A 40-year-old man comes to see the family doctor, holding a thick folder tightly to his chest.

Doctor (demonstrates effective non-verbal actions): Good afternoon. How may I address you?

Patient: I'm Oleksandr. Doctor, I have shortness of breath, abdominal pain, nausea. And today I also have a cough.

Doctor (demonstrates active listening skills): Mr. Oleksandr, I can see that you are upset. You are concerned about shortness of breath, abdominal pain, nausea, and a cough, right?

Patient: Yes.

Doctor: What do you think about your condition right now?

Patient (pauses): It all started with my divorce, I've been constantly ill since then, and then the endless arguments with my daughter, and lately the cough. Nothing helps, I probably have cancer.

Doctor: You're worried that you might have cancer and that's why the treatment you've been prescribed isn't working?

Patient: Yes.

Doctor: I noticed that you had already visited several doctors and had many tests done to try to uncover the cause of your diseases. I acknowledge that your symptoms are truly distressing for you, but I believe these tests have already ruled out any serious medical problems. (pauses)

Patient (nods): That's what the doctors are saying.

Doctor: Do you mind if I examine you? (commenting on his actions) I'll listen to your lungs, check your abdomen...

Patient nods.

Doctor: I'd like to make a plan with you to meet every three to four weeks, frequently enough to determine if there are any real changes in your condition. If something significant develops, we'll do additional tests. Our meetings will be frequent enough for you to feel confident that we're not missing anything. And we'll avoid unnecessary and costly tests and procedures if they're clearly not needed. Do you agree, Mr. Oleksandr?

Patient: Yes.

Doctor: I also recommend that you see a psychologist because you mentioned feeling worse after arguments with your daughter. We'll meet on December 6th. Does that work for you?

Patient: Yes.

The doctor listens to the patient attentively and patiently, understanding that the patient suspects he is seriously ill and that the doctors cannot make the correct diagnosis. The doctor delicately asks whether the deterioration in his condition might be related to family or work relationships. So, the doctor engages the patient in dialogue and explains that his psychological state may affect his physical sensations. He recommends that the patient also see a psychologist to cope with the emotionally difficult situation with his daughter.

7.5. The Depressed or Sad Patient

A hunched man enters the office, his head down, looking sad. He exhibits avoidant behaviour and shows a lack of interest in his surroundings. He speaks quietly, slowly, and sighs.

Doctor (demonstrating active listening skills): Good afternoon. How may I address you?

Patient: I'm Oleksandr.

Doctor: I can see from your expression that it might be difficult for you to talk. (pauses). Would you mind if I ask you some questions?

Patient nods.

Doctor: Tell me more about how you're feeling.

Patient: My heart hurts... I'm doing renovations at home. I lifted a bag of cement, and it started to hurt...

Doctor: It's good that you came here. I'll do everything I can to help you.

The doctor patiently listens to the patient, both verbally and non-verbally indicating that he is ready to hear the patient's complaints and will use all his skills to help him.

7.6. The Manipulative Patient

Doctor (demonstrating effective non-verbal actions): Good afternoon. How may I address you?

Patient: I'm Oleksandr. Please prescribe me medication "A"!

Doctor (demonstrating active listening skills): You want me to prescribe you medication "A", is that correct?

Patient (impatiently): Please prescribe me medication "A"!

Doctor: This medication is very strong. Tell me, what ails you? I can prescribe it after ensuring that other medications are ineffective.

Patient: I know more about my disease than any doctor. I've read a lot of literature and tried many medications, so I don't know how else you can help me.

Doctor: I see that you are well-informed. We will work together to overcome your problem. Are you agree?

Patient: Yes.

The doctor listens to the patient respectfully, despite the patient's insistence. He clarifies the patient's experience to engage him in dialogue and explains own position.

Doctor: This information is necessary for me to better understand you and to try to help you.

Patient: All doctors say that.

Doctor: So you've heard this before? I understand why you are cautious about providing information about yourself...

Patient: Maybe.

Doctor: We will work together to overcome your problem. Tell me more about it.

Patient: Alright. It's been a week, and now there's itching...

7.7. The Withdrawn Patient

A teenager visits the family doctor for a consultation. He is shy, keeps his head down, and blushes when speaking.

Doctor (demonstrating effective non-verbal actions): Good afternoon. How may I address you?

Patient is silent.

Doctor (demonstrating active listening skills): Please tell me how I may address you?

Patient: Oleksandr.

Doctor: Mr. Oleksandr, what ails you?

Patient blushes and remains silent.

Doctor (patiently): It seems you are uncomfortable talking about yourself. Imagine you are talking about a friend instead. Agreed? So, what ails him?

Patient: Diarrhoea.

Understanding the teenager's embarrassment, the doctor employs a creative approach — asking him to describe his friend's complaints instead of his own. This step helps establish a connection between the teenager and the doctor, laying the foundation for a trusting relationship.

7.8. The Talkative Patient

A patient visits the family doctor for a consultation, behaving somewhat theatrically and speaking in a confident tone.

Doctor (demonstrating effective non-verbal actions): Good afternoon. How may I address you?

Patient: I'm Oleksandr. I have a headache. I work without rest and I'm concerned about my condition. It happened a month ago, but it went away quickly. I was at a party with friends, and I felt bad there. I can't stand being in pain. I like everything to be perfect. Besides, I can't take sick leave because there's no one to trust with my work. Sometimes it seems...

Doctor (demonstrating active listening skills): I see you like everything to be perfect, and I understand that's very important to you. Can you tell me if this might be affecting your health?

Patient: Yes. I love everything to be perfect.

Doctor: How are you feeling now?

Patient: Nausea, headache...

The doctor listens attentively to the patient, paraphrases his words, shows interest in the conversation, but sets priorities.

QUESTIONS FOR SELF-ASSESSMENT

1. What are the methods of active listening?
2. What is non-verbal communication with patients and family members?
3. What is verbal communication with patients and family members?
4. What are the signs of effective communication?
5. Name three communication skills.
6. List the facilitation skills.
7. Name effective actions in implementing Nils Grenstad's "Three-Step Rocket" technique.
8. What are the personal qualities of an effective doctor?
9. List psychological characteristics that may reduce communicative competence.
10. Explain four models of "doctor-patient" interaction.
11. Describe modern approaches to understanding and classifying personality disorders in DSM-5 (Cluster A, Cluster B, Cluster C).
12. Describe the traditional model of information gathering.
13. Detail the alternative model of information gathering. A patient-centred approach to information gathering.
14. What are the types of complex patients?
15. What is the CLASS protocol?
16. Name 5 key stages of "doctor-patient" communication.
17. What are the effective actions of the CONES protocol?
18. What are the effective actions of the EVE protocol?
19. What are the effective actions of the SPIKES protocol?
20. What are the effective actions of the BUSTER protocol?
21. Describe the Calgary–Cambridge Basic Medical Consultation Model.
22. What is the definition of mindfulness?
23. How is the mindfulness program beneficial for doctors?
24. How to use the TIMER protocol?
25. What is assertive behaviour?

TEST TASKS

1. What protocol is used during emotionally complex conflict situations involving the patient and his relatives?
   A. BUSTER.
   B. EVE.
   C. CONES.
   D. SPIKES.

2. Effective actions of the CONES protocol:
   A. Space organisation. Permission to discuss. Chronology. Empathetic reaction. Further actions.
   B. Organizing space for discussion. Effective listening. Reflecting a patient's feelings. Collaborative treatment plan with the patient. Summary.
   C. Explore emotions. Validate emotions. Empathetic response.
   D. Be prepared. Use unbiased listening. Rule of six seconds. Statement "Tell me more". Show empathy and validation. Respond through the "wish" construction.

3. Effective actions of the EVE protocol:
   A. Space organisation. Permission to discuss. Chronology. Empathetic reaction. Further actions.
   B. Organizing space for discussion. Effective listening. Reflecting a patient's feelings. Collaborative treatment plan with the patient. Summary.
   C. Explore emotions. Validate emotions. Empathetic response.
   D. Be prepared. Use unbiased listening. Rule of six seconds. Statement "Tell me more". Show empathy and validation. Respond through the "wish" construction.

4. Effective actions of the TIMER protocol:
   A. Space organisation. Permission to discuss. Chronology. Empathetic reaction. Further actions.
   B. Prepare for the meeting. Familiarise yourself with the problems. Facilitate the discussion. Create a plan and expectations. Provide feedback.
   C. Explore emotions. Validate emotions. Empathetic response.
   D. Be prepared. Use unbiased listening. Rule of six seconds. Statement "Tell me more". Show empathy and validation. Respond through the "wish" construction.

5. Effective actions of the SPIKES protocol:
   A. Space organisation. Permission to discuss. Chronology. Empathetic reaction. Further actions.
   B. Prepare the space for discussion. Effective listening. Reflecting a patient's feelings. Agree on a treatment plan with the patient. Summary.
   C. Space organisation for discussion, internal readiness for a difficult conversation. Gathering information, patient's thoughts on the disease, involving the patient in the decision-making process. Patient's readiness to know about his disease. Delivering bad news. Empathetic response. Discussing treatment.
   D. Be prepared. Use unbiased listening. Rule of six seconds. Statement "Tell me more". Show empathy and validation. Respond through the "wish" construction.

6. Effective actions of the BUSTER protocol:
   A. Space organisation. Permission to discuss. Chronology. Empathetic reaction. Further actions.
   B. Prepare the space for discussion. Effective listening. Reflecting a patient's feelings. Agree on a treatment plan with the patient. Summary.
   C. Explore emotions. Validate emotions. Empathetic response.
   D. Be prepared. Use unbiased listening. Rule of six seconds. Statement "Tell me more". Show empathy and validation. Respond through the "wish" construction.

7. In which protocol is the SMART model used:
   A. BUSTER.
   B. TIMER.
   C. CONES.
   D. SPIKES.

8. Organization of space (office) and doctor includes:
   A. Order, absence of unnecessary things, external triggers (phone on silent mode, avoiding current issues if possible).
   B. Fresh air, warm room. Tissues, water. Internal setting. Neat appearance.
   C. Safe space (comfortable arrangement of table, chairs, sign, soundproofing). Comfortable colour scheme of walls.
   D. All answers are correct.

9. Skills of effective interaction between doctor and patient:
   A. Open body posture, encouragement: verbally/non-verbally — nodding, appropriate facial expressions, gestures, "yes".
   B. Eye contact, facial expression, appropriate pace.
   C. Tone of voice, facial expression, reflection of emotions/feelings.
   D. All answers are correct.

10. Facilitation skills:
    A. Encouragement, repetition of the patient's last few words, paraphrasing.
    B. Pause. Paraphrasing.
    C. Doctor's expression of thoughts. Attention to patient's non-verbal and verbal cues.
    D. All answers are correct.

11. Active listening skills:
    A. Waiting time. Facilitation. Doctor's non-verbal skills. Patient's non-verbal skills.
    B. Waiting time. Doctor's non-verbal skills. Patient's non-verbal skills.
    C. Doctor's non-verbal skills. Patient's non-verbal skills.
    D. All answers are correct.

12. "Three-Step Rocket" method:
    A. Verbal and non-verbal patient reaction to objective information. Notification of doctor's own feelings to enhance trustful communication.
    B. Doctor's response to patient's reaction, paraphrasing, doctor's own feelings.
    C. Verbal and non-verbal doctor's response to patient's reaction. Paraphrasing to encourage patients to express feelings.
    D. All answers are correct.

13. Calgary–Cambridge communication model:
    A. A model of medical consultation for delivering bad news, consisting of 74 questions.
    B. Basic model of medical consultation, consisting of 73 questions.
    C. Model of medical consultation, consisting of 70 questions.
    D. All answers are incorrect.

14. Doctor for establishing contact:
    A. Recognizes the validity of the patient's views and feelings without judgement.
    B. Shows empathy to express understanding and respect for the patient's feelings and difficulties, openly acknowledges the value of his views and feelings.
    C. Provides support: cares, understands, expresses a willingness to help, offers partnership. Shows sensitivity, which means he approaches delicate and unpleasant topics and physical pain carefully.
    D. All answers are correct.

15. Goals of building effective relationships between doctor and patient:
    A. Achieving mutual understanding so that the patient feels understood, valued, and supported. Conflict prevention.
    B. During the consultation, laying the foundation for trusting relationships. Psychological support is provided.
    C. The patient is engaged in the treatment process and actively participates in it.
    D. All answers are correct.

16. Communication skills for building trust that the doctor uses throughout the consultation:
    A. Verbal and non-verbal communication skills.
    B. Content, process, perception skills.
    C. Perception of the communication process.
    D. All is correct.

17. The use of pauses provides the doctor with:
    A. Time for reflection.
    B. The opportunity to receive valuable information from the patient about the disease.
    C. Encouragement for the patient to express his thoughts and feelings.
    D. All is correct.

18. Definition of mindfulness:
    A. The technique of choosing a conscious life and pursuing a goal, readiness of the mind and spirit for surprises, and fidelity to one's values.
    B. Meditation.
    C. Awareness that helps improve attention and reduce stress levels.
    D. All answers are correct.

19. Protocol for structured information transfer among healthcare professionals, particularly during handover of responsibility or important patient condition information:
    A. SBAR and ISBAR.
    B. TIMER.
    C. CONES.
    D. SPIKES.

20. Definition of character:
    A. The set of stable individual personality traits, "special features", acquired by a person while living in society.
    B. The speed and depth of a person's emotional reaction to events.
    C. Impulsive reaction, spontaneity.
    D. Stable individual personality traits expressed in the dynamics of mental processes and actions, based on the anatomical and physiological characteristics of the human brain and endocrine system.

CASE STUDIES

1. The patient comes for a follow-up visit to the doctor. Angrily addresses the specialist, “I’ve been taking the drug “A” every day for two weeks, as you prescribed, and my blood pressure isn’t going down, there’s no benefit from these pills!”
   Doctor:
   A. “Good day, it’s good that you mentioned that you’re regularly taking this drug. Let’s add the drug “B”, and in two days we’ll discuss the effectiveness of the treatment.”
   B. “Good day! I’m sure you just forgot to take them!”
   C. “Why are you shouting at me? How could I know they do not help you?!”
   D. “Good day! That’s very bad news. I thought they were effective since you didn’t attend the appointment.”

2. A patient visits a surgeon for consultation. The doctor invites the patient into the office, offers him a seat, and gets distracted by a conversation with a colleague, “Excuse me, we have an urgent matter about surgery. Can you wait for 5 minutes?” The patient agrees, but after a minute, rudely asks the doctor, “How much longer do I have to wait???”
   Doctor:
   A. Demonstrates active listening skills, “I understand why you’re upset, and I appreciate you waiting for me. Thank you.”
   B. Annoyed, “That was an important conversation, so what’s bothering you?”
   C. Indifferently, “What’s bothering you?”
   D. Rudely, “Listen, we had a very important conversation, I warned you!”

3. In the corridor, a doctor meets his patient, who appears confused and nervous. The patient says, “Doctor, I wanted to ask about my diagnosis.”
   Doctor:
   A. Demonstrates active listening skills, invites the patient to the office or suggests a more comfortable place, “Good day, Mr. O. I hear the concern in your voice. I understand you want to know about your diagnosis today, but we need to wait for the test results. Is it convenient to meet on September 5th at 10:00?”
   B. “What troubles you? I’ll do everything to help you with your problem. Let’s meet on September 5th at 10:00. Is that convenient?”
   C. “Our appointment is scheduled for 10:00 on September 5th, that’s when the lab results will be ready, and I’ll inform you.”
   D. “I’ll give you the results on September 5th during the appointment.”

4. A patient enters the office looking sad, displaying avoidant behaviour and disinterest in the surroundings. The doctor demonstrates active listening skills and says, “Good day. My name is... I’m a family doctor. How can I address you?” The patient responds very quietly and slowly, “I’m O.”
   Doctor:
   A. “I see the expression on your face, it seems like you’re feeling down. (pause) Maybe it’s difficult for you to speak? (pause) Would you mind if I asked how you’re feeling?”
   B. Indifferently, “What ails you?”
   C. Sympathetically, “O., what brought you here?”
   D. Impatiently, “O., speak up, please, louder. So, what ails you?”

5. Doctor, “Good day. My name is... I’m a family doctor. How can I address you?” The patient (hurriedly), “I’m O., I have a headache. I work a lot. I like everything to be perfect. Recently, I felt sick on my way back from a business trip. Nausea. A similar thing happened to my friend...”
   Doctor:
   A. Quickly, “How do you feel now?”
   B. “I see how important your work is to you, but could we return to it a bit later? Tell me more about your headache. Agree?”
   C. Demonstrates active listening skills, “I hear you, Mr. O., rushing to tell everything. (pause) You have a headache, nausea, you work a lot, and you like everything to be perfect, right? (pause) Anything else?”
   D. “Yes, stop. You don’t need to talk about your friend.”

6. At a consultation with a family doctor, a young man complains, “Doctor, my stomach has been rumbling all day. I’m really scared that I might have cancer.”
   Doctor:
   A. “Oh, that’s nothing to worry about, you shouldn’t be concerned about it.”
   B. “It’s good that you’re attentive to your health. It could be related to such a condition. We’ll conduct a thorough examination and determine if you’re healthy. Are you okay with that?”
   C. “I see you’re worried about the rumbling in your stomach and you’re afraid of getting cancer. Can you tell me, maybe there were

circumstances that made you start fearing to get sick? (pause) If necessary, we'll conduct the necessary tests."
D. I have rumbling in my stomach too in the morning. But I have no cancer.

7. The head of the department calls the resident, "I'd like to talk to you about your delays. I appreciate you. You're a good worker, but you're always 30 minutes late for every duty shift."
Resident:
A. "What happened? I always come on time. That's not true."
B. "Sorry, I really get delayed, I drop off my child at my mother's. Maybe we can set up the work schedule a bit?"
C. "And when you're an hour late, does that matter?"
D. "If you valued me, you wouldn't talk about such trivial matters!!!"

8. A doctor meets with a patient's relatives in the corridor, who is in the intensive care unit. The patient's daughter tells in an accusing tone, "How could you let my father get worse?"
Doctor:
A. "I know how you feel right now. I feel your pain."
B. "Don't worry. Everything will be fine."
C. "I won't talk to you in that tone."
D. Invites them to the office, offers a seat, "Thank you for coming. I need to tell you what's happening with your father."

9. In the oncology clinic, a patient's mother died. The son comes and learns that his mother is no longer alive. In anger, he accuses the entire staff of negligence. He is accompanied to the doctor. "How could it happen that yesterday I was talking to my mother, and now you're saying she's gone???", the visitor asks loudly.
Doctor:
A. Maintains eye contact, offers to sit down, "This is difficult, but I need to tell you about your mother. She fought the disease, underwent chemotherapy well, but her heart stopped overnight. We did everything we could. If you have any questions, I'm ready to answer them."
B. Lowers eyes, "Most people have felt that way. I'm sorry."
C. "I will prepare all the documents, you can verify, there were no errors in the treatment. Would you like to conduct an examination?"
D. "Let me tell you step by step about the treatment we provided to your mother."

10. A patient comes to the oncologist for a follow-up appointment after a complete examination. The doctor has the test results, diagnosis: malignant tumour. It is necessary to inform the patient about the seriousness of the condition. "Good day! Please, have a seat. I would like to ask you, how do you feel, what do you think about your condition?" Listens to the patient's response.
Doctor:
A. "Would you like to know the details of the examination?"
B. "The examination showed that you have a malignant tumor..."
C. Maintaining eye contact, "Perhaps you have questions you'd like to ask? Discuss details of the examination?"
D. "I want to support you. Don't worry, everything will be fine."

11. A patient enters the office, looking sad. The doctor demonstrates effective non-verbal actions.
Doctor, "Good day. My name is... I'm a family doctor. How may I address you?"
Patient, "Olexander."
Doctor, "Mr. Olexander, what ails you?"
The patient remains silent.
Doctor:
A. Patiently, "I feel like you're hesitant to talk about yourself?"
B. "What ails you?"
C. Impatiently, "If you don't want to tell me anything, that's another matter, just tell me, 'I don't want to talk to you'."
D. Waits for a response.

12. Patient calls the doctor in the evening, "Please, schedule me for tomorrow at 8:00 in the morning. It will be convenient for me."
Doctor:
A. "Good evening. Yes, see you then."
B. "Good evening. I have appointments starting in the afternoon tomorrow. I can schedule you for 3:00 pm. Will that time work for you?"
C. Does not pick up the phone.
D. "Why are you calling so late?"

13. A man visits his family doctor complaining, “Doctor, I have a rash on my stomach.”
Doctor:
A. “Let me examine you.”
B. “Tell me in detail, and then I will examine you.”
C. “When did the rash appear?”
D. “Is there any itching?”

14. A young mother visits the family doctor with her five-year-old daughter. The child calmly enters the doctor’s office (holding a doll), looks at the pictures on the wall in the doctor’s office. The mother says to the child, “No injections will be made.”
Doctor:
A. To the mother and the girl, pointing to two chairs, “Good afternoon. Please, come in and have a seat.” Addressing her mother, “How may I address you?” To the girl, “And you? What’s your doll’s name?”
B. “I see you’re worried. Don’t worry, mother.”
C. “What ails you?”
D. “Mom! What a fuss are you making? Don’t scare the child!”

15. The endoscopy room for stomach examination. A nervous girl enters for the procedure.
Doctor:
A. Impatiently, “You’re not a child, why tremble like this... Open your mouth.”
B. Calmly, “Yes, I understand, the procedure isn’t very pleasant. Let me explain... I’ll insert the scope and look at the lining of your stomach... Are you ready?”
C. “Go and calm yourself down, then come back. I don’t have time to comfort you.”
D. Roughly, “What’s this all about?”

16. A patient comes to the dermatologist for a consultation. She tells about a black mole that has doubled in size over the past month. She’s afraid it might be melanoma.
Doctor:
A. Impatiently, “There’s no reason to overthink this.”
B. “It’s good that you’re taking care of your health and came to the clinic. I will examine you, and then we’ll discuss everything.”
C. “They read too many articles on the Internet, and then they can’t sleep at night. You don’t have any melanoma.”
D. All answers are correct.

17. An 18-year-old girl accompanied by her mother comes for a consultation with the gynecologist. The mother takes the initiative and starts explaining that her daughter has stopped menstruating and lost 10 kilograms. The doctor addresses the girl first and then the mother, “How may I address you?” Listens attentively and asks the girl if she would like to add anything. Gently clarifies if the girl would be comfortable with her mother present during the examination. The girl timidly shakes her head.
Doctor (addresses her mother):
A. “Could you wait in the waiting area? Your daughter is already an adult.”
B. “I understand you’re concerned about your daughter’s health, let’s invite you to the office after the examination. Is that okay with you?”
C. “The girl can speak for herself, there’s no need to do it for her.”
D. All answers are correct.

REFERENCES

1. Pavlenko T. M. (2018). Personality disorders: evolution of views and modern conceptualisation. *Journal of Neuronews Psychoneurology and Neuropsychiatry,* 4–5 (97), 36–39. (In Ukrainian) https://neuronews.com.ua/ua/archive/2018/4-5%2897%29/pages-36-39/rozladi-osobistosti-evolyuciya-poglyadiv-i-suchasna-konceptualizaciya#gsc.tab=0
2. McWilliams, N. (2011). Psychoanalytic diagnosis: Understanding personality structure in the clinical process (2nd ed.). Guilford Press.
3. McWilliams, N. (2021). *Psychoanalytic supervision*. Guilford Publications.
4. Asanova A., & Khaustova O. (2018). Typical difficult situations in doctor-patient interactions. *Psychosomatic Medicine and General Practice, 3* (3), e0303125. https://doi.org/10.26766/pmgp.v3i3.125
5. Minicuci, N., Giorato, C., Rocco, I., Lloyd-Sherlock, P., Avruscio, G., & Cardin, F. (2020). Survey of doctors' perception of professional values. *PloS one, 15* (12), e0244303. https://doi.org/10.1371/journal.pone.0244303
6. Suchman A., Sluyter D., and Williamson, P. (2011) *Leading Change in Healthcare: transforming organizations using complexity, positive psychology and Relationshipcentered Care*. Oxford, UK: Radcliffe Publishing;
7. Frankel, Richard M.; Quill, Timothy E. & McDaniel, Susan H. (eds.) (2003). *The biopsychosocial approach: past, present, and future*. Rochester, NY: University of Rochester Press.
8. Silverman, J., & Kinnersley, P. (2010). Doctors' non-verbal behaviour in consultations: look at the patient before you look at the computer. *The British journal of general practice: the journal of the Royal College of General Practitioners, 60* (571), 76–78. https://doi.org/10.3399/bjgp10X482293
9. Puntis M. (2006). Skills for Communicating with Patients (2nd edn). *Annals of The Royal College of Surgeons of England, 88* (1), 85–86. https://doi.org/10.1308/003588406X83159c
10. Chichirez, C. M., & Purcărea, V. L. (2018). Interpersonal communication in healthcare. *Journal of medicine and life, 11* (2), 119–122.
11. Anderson, R. J., Bloch, S., Armstrong, M., Stone, P. C., & Low, J. T. (2019). Communication between healthcare professionals and relatives of patients approaching the end-of-life: A systematic review of qualitative evidence. *Palliative medicine, 33* (8), 926–941. https://doi.org/10.1177/0269216319852007
12. Marler, H., & Ditton, A. (2021). "I'm smiling back at you": Exploring the impact of mask wearing on communication in healthcare. *International journal of language & communication disorders, 56* (1), 205–214. https://doi.org/10.1111/1460-6984.12578
13. Belrhiti, Z., Nebot Giralt, A., & Marchal, B. (2018). Complex Leadership in Healthcare: A Scoping Review. *International journal of health policy and management, 7* (12), 1073–1084. https://doi.org/10.15171/ijhpm.2018.75
14. Liukka, M., Steven, A., Moreno, M. F. V., Sara-Aho, A. M., Khakurel, J., Pearson, P., Turunen, H., & Tella, S. (2020). Action after Adverse Events in Healthcare: An Integrative Literature Review. *International journal of environmental research and public health, 17* (13), 4717. https://doi.org/10.3390/ijerph17134717
15. Lo, L., Rotteau, L., & Shojania, K. (2021). Can SBAR be implemented with high fidelity and does it improve communication between healthcare workers? A systematic review. *BMJ open, 11* (12), e055247. https://doi.org/10.1136/bmjopen-2021-055247
16. Kuosmanen, L., Hupli, M., Ahtiluoto, S., & Haavisto, E. (2021). Patient participation in shared decision-making in palliative care — an integrative review. *Journal of clinical nursing, 30* (23–24), 3415–3428. https://doi.org/10.1111/jocn.15866
17. Moreira, F. T. L. D. S., Callou, R. C. M., Albuquerque, G. A., & Oliveira, R. M. (2019). Effective communication strategies for managing disruptive behaviors and promoting patient safety. Estratégias de comunicação efetiva no gerenciamento de comportamentos destrutivos e promoção da segurança do paciente. *Revista gaucha de enfermagem, 40* (spe), e20180308. https://doi.org/10.1590/1983-1447.2019.20180308
18. Kim, M. Y., & Oh, S. (2020). Nurses' Perspectives on Health Education and Health Literacy of Older Patients. *International journal of environmental research and public health, 17* (18), 6455. https://doi. org/10.3390/ijerph17186455
19. Liu, P., Lyndon, A., Holl, J. L., Johnson, J., Bilimoria, K. Y., & Stey, A. M. (2021). Barriers and facilitators to interdisciplinary communication during consultations: a qualitative study. *BMJ open, 11* (9), e046111. https://doi.org/10.1136/bmjopen-2020-046111
20. Oreja-Guevara, C., Potra, S., Bauer, B., Centonze, D., Giambastiani, M. P., Giovannoni, G., Kesselring, J., Langdon, D., Morrow, S. A., Nouvet-Gire, J., Pontaga, M., Rieckmann, P., Schippling, S., Alexandri, N., Shanahan, J., Thompson, H., Van Galen, P., Vermersch, P., & Yeandle, D. (2019). Joint Healthcare Professional and Patient Development of Communication Tools to Improve the Standard of MS Care. *Advances in therapy, 36* (11), 3238–3252. https://doi.org/10.1007/s12325-019-01071-9
21. Agaronnik, N., Campbell, E. G., Ressalam, J., & Iezzoni, L. I. (2019). Communicating with Patients with Disability: Perspectives of Practicing Physicians. *Journal of general internal medicine, 34* (7), 1139–1145. https://doi.org/10.1007/s11606-019-04911-0
22. Vela, M. B., Erondu, A. I., Smith, N. A., Peek, M. E., Woodruff, J. N., & Chin, M. H. (2022). Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. *Annual review of public health, 43*, 477–501. https://doi.org/10.1146/annurev-publhealth-052620-103528
23. Quarello, P., Toss, A., Berchialla, P., Mascarin, M., Lambertini, M., Canesi, M., Maria Milano, G., Incorvaia, L., Luigi Banna, G., Peccatori,

F., & Ferrari, A. (2023). Healthcare Professional Communication on Sexual Health: A Report from the Italian Working Group on Adolescents and Young Adults with Cancer. *The oncologist, 28* (10), e884–e890. https://doi.org/10.1093/oncolo/oyad175
24. Madula, P., Kalembo, F. W., Yu, H., & Kaminga, A. C. (2018). Healthcare provider-patient communication: a qualitative study of women's perceptions during childbirth. *Reproductive health, 15* (1), 135. https://doi.org/10.1186/s12978-018-0580-x
25. Alsaleh, H., & Alshammari, T. M. (2021). Direct healthcare professional communications: A quantitative assessment study. *Pharmacology research & perspectives, 9* (3), e00763. https://doi.org/10.1002/prp2.763
26. Carvalho, I. P., & Dores, A. R. (2022). Clinical Communication in Rehabilitation. *International journal of environmental research and public health, 19* (12), 7268. https://doi.org/10.3390/ijerph19127268
27. Pitts, E., Wylie, K., Loftus, A. M., & Cocks, N. (2022). Communication strategies used by Parkinson's nurse specialists during healthcare interactions: A qualitative descriptive study. *Journal of advanced nursing, 78* (6), 1773–1786. https://doi.org/10.1111/jan.15196
28. Susilo, A. P., Benson, J., Indah, R., & Claramita, M. (2023). Editorial: Patient-centered communication skills for health professions education and healthcare. *Frontiers in public health, 11*, 1311905. https://doi.org/10.3389/fpubh.2023.1311905
29. Sabot, K., Blanchet, K., Berhanu, D., Spicer, N., & Schellenberg, J. (2020). Professional advice for primary healthcare workers in Ethiopia: a social network analysis. *BMC health services research, 20* (1), 551. https://doi.org/10.1186/s12913-020-05367-3
30. Siegel, R. M., Haemer, M., Kharofa, R. Y., Christison, A. L., Hampl, S. E., Tinajero-Deck, L., Lockhart, M. K., Reich, S., Pont, S. J., Stratbucker, W., Robinson, T. N., Shaffer, L. A., & Woolford, S. J. (2018). Community Healthcare and Technology to Enhance Communication in Pediatric Obesity Care. *Childhood obesity (Print), 14* (7), 453–460. https://doi.org/10.1089/chi.2017.0339
31. Preis, H., Dobias, M., Cohen, K., Bojsza, E., Whitney, C., & Pati, S. (2022). A mixed-methods program evaluation of the Alda Healthcare Experience — a program to improve healthcare team communication. *BMC medical education, 22* (1), 897. https://doi.org/10.1186/s12909-022-03972-w
32. Møllebaek, M., & Kaae, S. (2021). Why do general practitioners disregard direct to healthcare professional communication? A user-oriented evaluation to improve drug safety communication. *Basic & clinical pharmacology & toxicology, 128* (3), 463–471. https://doi.org/10.1111/bcpt.13516
33. Cubaka, V. K., Schriver, M., Cotton, P., Nyirazinyoye, L., & Kallestrup, P. (2018). Providers' perceptions of communication with patients in primary healthcare in Rwanda. *PloS one, 13* (4), e0195269. https://doi.org/10.1371/journal. pone.0195269
34. Working Party of the Royal College of Physicians (2005). Doctors in society. Medical professionalism in a changing world. *Clinical medicine (London, England), 5* (6 Suppl 1), S5–S40.
35. Fewster-Thuente, L., & Velsor-Friedrich, B. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing administration quarterly, 32* (1), 40–48. https://doi.org/10.1097/01.NAQ.0000305946. 31193.61
36. Pirraglia, P. A., Hampton, J. M., Rosen, A. B., & Witt, W. P. (2011). Psychological distress and trends in healthcare expenditures and outpatient healthcare. *The American journal of managed care, 17* (5), 319–328.
37. Smailhodzic, E., Hooijsma, W., Boonstra, A., & Langley, D. J. (2016). Social media use in healthcare: A systematic review of effects on patients and on their relationship with healthcare professionals. *BMC health services research, 16* (1), 442. https://doi.org/10.1186/s12913-016-1691-0
38. Austin W. (2016). Contemporary healthcare practice and the risk of moral distress. *Healthcare management forum, 29* (3), 131–133. https://doi.org/10.1177/0840470416637835
39. Singhal, A., & Borrelli, B. (2017). Dental Disparities and Psychological Distress Among Mobility-Impaired Adults. *American journal of preventive medicine, 52* (5), 645–652. https://doi.org/10.1016/j.amepre.2016.10.025
40. Priebe, S., & Mccabe, R. (2008). Therapeutic relationships in psychiatry: the basis of therapy or therapy in itself? *International review of psychiatry (Abingdon, England), 20* (6), 521–526. https://doi.org/10.1080/09540260802565257
41. DiNapoli, J. M., O'Flaherty, D., Musil, C., Clavelle, J. T., & Fitzpatrick, J. J. (2016). The Relationship of Clinical Nurses' Perceptions of Structural and Psychological Empowerment and Engagement on Their Unit. *The Journal of nursing administration, 46* (2), 95–100. https://doi.org/10.1097/ NNA.0000000000000302
42. Dass-Brailsford, P., & Myrick, A. C. (2010). Psychological trauma and substance abuse: the need for an integrated approach. *Trauma, violence & abuse, 11* (4), 202–213. https://doi.org/10.1177/1524838010381252
43. Puntis M. (2006). Skills for Communicating with Patients (2nd edn). *Annals of The Royal College of Surgeons of England, 88* (1), 85–86. https://doi.org/10.1308/003588406X83159c
44. Rajaram U. (2012). The patient-doctor relationship. *Indian journal of medical ethics, 9* (3), 156–157. https://doi.org/10.20529/IJME.2012.051
45. Lamiani, G., Borghi, L., & Argentero, P. (2017). When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *Journal of health psychology, 22* (1), 51–67. https://doi.org/10.1177/1359105315595120
46. Street, R. L., Jr, Elwyn, G., & Epstein, R. M. (2012). Patient preferences and healthcare outcomes: an ecological perspective. *Expert review of pharmacoeconomics & outcomes research, 12* (2), 167–180. https://doi.org/10.1586/erp.12.3
47. Baile, W. F., Buckman, R., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P. (2000). SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. *The oncologist, 5* (4), 302–311. https://doi.org/10.1634/theoncologist.5-4-302

48. Von Blanckenburg, P., Hofmann, M., Rief, W., Seifart, U., & Seifart, C. (2020). Assessing patients´ preferences for breaking Bad News according to the SPIKES-Protocol: the MABBAN scale. *Patient education and counseling, 103* (8), 1623–1629. https://doi.org/10.1016/j.pec.2020.02.036
49. Kaplan M. (2010). SPIKES: a framework for breaking bad news to patients with cancer. *Clinical journal of oncology nursing, 14* (4), 514–516. https://doi.org/10.1188/10.CJON.514-516
50. Peixoto, V. G. M. N. P., Diniz, R. V. Z., & Godeiro, C. O. (2020). SPIKES-D: a proposal to adapt the SPIKES protocol to deliver the diagnosis of dementia. *Dementia & neuropsychologia, 14* (4), 333–339. https://doi.org/10.1590/1980-57642020dn14-040001
51. Dean, A., & Willis, S. (2016). The use of protocol in breaking bad news: evidence and ethos. *International journal of palliative nursing, 22* (6), 265–271. https://doi.org/10.12968/ijpn.2016.22.6.265

APPENDIX A

QR Code Link to Video Overview of the CLASS Protocol

APPENDIX B

QR Code Link to Video Overview of the BUSTER Protocol and the CONES Algorithm

APPENDIX C

QR Code Link to Video Overview of the SPIKES Protocol: Breaking Bad News During Patient Consultation

APPENDIX D

QR Code Link to Video Overview of Unprofessional Doctor Behavior During Patient Consultation

Answers to test tasks

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
A	✓	✓									✓								✓	✓
B				✓			✓						✓			✓				
C			✓		✓															
D						✓		✓	✓	✓		✓		✓	✓		✓	✓		

Answers to situational problems

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
A	✓	✓	✓	✓					✓		✓			✓			
B							✓					✓	✓		✓	✓	✓
C					✓	✓				✓							
D								✓									

У навчальному посібнику висвітлено основні принципи й методики спілкування лікаря з пацієнтом у різноманітних ситуаціях.

Для здобувачів вищої освіти, лікарів-інтернів, лікарів усіх спеціальностей.

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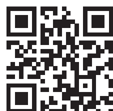

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