

Healthcare/Patient Interactions and the Possible Pitfalls – A Narrative Review

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I write this review by way of sharing with healthcare practitioners (HCP's) around the globe, the possible pitfalls of not considering patient interactions in an holistic manner. By not doing so, complaints to the HCP's individual medical regulating authority may arise. This was certainly the case for me. However, more importantly, by making this consideration during the patient encounter, it will lead to the delivery of a better service and outcome to said patients. In this piece I will outline the steps I incorporate in said patient interactions that will lead to better service delivery and outcomes of patient care.

Overview of patient interaction

Once I have completed the initial subjective examination of a patient (history of present condition (this will include symptoms, onset, aggravating/easing factors, musculo-skeletal (msk) red flag special questions etc.) I then take a comprehensive past medical history (pmh) e.g. any surgeries, allergies, current and past medication, exercise, major diseases (e.g. diabetes, cancer). I then perform a series of area of complaint, specific special tests, in order to elucidate what the cause/origin/structure could be responsible for the patient's condition. Once I have completed my physical assessment I then verbally summarize the physical examination findings with my patient followed by what tests were used during the initial assessment session that proved beneficial to them, in either reducing their pain or what was needed to improve their condition (gait, posture, stretching, mobilization's etc.). I then ask if they have any questions surrounding my findings and the way forward re treatment that I have suggested for them based on my subjective and objective examination. This is as per my usual practice. What has changed is that I have now adopted having the patient sign on the notes at the point where I have given this explanation as an additional step. I have introduced this extra step into my practice as it demonstrates they are happy to proceed with treatment and that they have understood the results and explanations. This serves as consent and shared

decision-making parameters being fulfilled. Although this may be seen as a processed type of mechanism i.e. tick box, it is more than that. That is to say, I have explained to the patient what their condition is and what is the best way to move forward in my opinion, so if you are happy to proceed now tick this box and let us move on with the process. If not, what is it that you are unhappy with and lets us try and come up with an alternative approach that you are happy with? This is an example of a "transactional relationship". This derives itself from the concept of transactional analysis (TA). This construct will be addressed later on in this piece.

I will quickly mention here that, it is important that when going through this "tick box" approach seen in TA, that it not be a cold one sided mechanism, whereby the clinician says "you have a, b and c and we will do d, e and f to make it better. This process must be presented in a kind, caring and gentle manner, such that the patient feels part of the process and is happy with it (shared decision making). At all times, the patient must feel they can be involved in the process and modify it in a way that suits their lifestyle, disposition and comfort. An example of this would be "I recommend you perform these exercises every hour. All the exercises I have given you take 20 minutes to perform". For most working people with a family this would be impossible to administer into their everyday life. This prescription is not only unrealistic to adhere to but unrealistic in its goal setting standard. Finding the happy medium of information presentation, acceptable prescription that best suits the individual, is the true art of patient interaction that all clinicians should strive for.

Why is this an important premise? It is important because, if information and care delivery is not presented in a manner that is understood by the patient, then a negative outcome for both the HCP and patient may arise. For the HCP this can result in the patient being unhappy with the interaction and either not using your services again or even worse, making a

formal complaint against you. For the patient this may result in noncompliance in performing the suggested treatment, or as is the case with many “chronic pain patients” (CPP), result in further negativity surrounding both their condition and any and all interactions they will have with HCP [1]. In fact, 62% of the Okifuji [1] study population cited anger directed at the HCP. It is therefore vital that HCP’s are able to firstly identify CPP and treat and convey their treatment in an appropriate manner to this special patient group. Why is it important to identify CPP individuals? As stated, CPP tend to have a negativity surrounding their condition and their interaction with HCP’s. One probable reason is that they have seen numerous HCP’s and they still have their pain. Understandably, CPP’s, have a loss of faith in HCP’s, along with a deepening belief that their condition is permanent and irreversible (this belief is often present in this group of patients). It is important to state that, unfortunately, some conditions are permanent and irreversible.

In general, people in Western societies turn to their respective health care system in order to access help for a variety of physiological and psychosomatic/psychosocial health problems. By entering into this system, they obviously become “patients and find themselves within a system of practices, that conceptualizes their bodies as objective bodies, treat their ill health in terms of the malfunctioning machine, and compartmentalizes their lived experiences into medically interpreted symptoms and signs of underlying biological dysfunction” [2]. By adopting this approach, the HCP is seeing the patient as just a problem to solve. This is not how ANY patient should be approached. The problem-solving aspect of patient care should only be one of the considerations the HCP needs to adopt when interacting with any patient.

Many authors have stated that CPP’s can catastrophize an encounter with an HCP [3-10]. Catastrophising the encounter with an HCP will be further complicated and more likely result in a complaint if the patient has a psychopathological factor to their pain. This is not limited to psychological disorders (eg. multisomatiform dysfunction) but also learning disabilities (eg. Dyslexia) [10a]. These individuals have developed a sense of “perceived injustice” [3], therefore no matter what is done to help them, anything other than an instant and full “cure” will result in a negative outcome being perceived by them [3]. Therefore, a good way around this point is to ask these individuals: “what do you want to achieve and or expect to achieve by coming to see me today”? This will lead to the patient having to summarize their condition from a problem-solving perspective. In doing so, they may glean insight into the issues surrounding the achievement of their goals. It is not that an HCP should be less interactive with a CPP. In many instances this maybe appropriate in others a more robust approach might be indicated if the CPP has been to many other HCP’s before seeing you and is desperate for a cure where others have either failed due to inappropriate treatment or lack of treatment due to correctly surmising a ‘hands off’ approach is best with these individuals. It is hard to define what is the best approach for any patient. A comprehensive systematic review by Guzman in 2001 [4] that encompassed 12 randomised controlled trials that

had an accumulative cohort of 1964 patients with “chronic low back pain” found that “the reviewed trials provide evidence that intensive multidisciplinary biopsychosocial rehabilitation with functional restoration reduces pain and improves function in patients with chronic low back pain. Less intensive interventions did not show improvements in clinically relevant outcomes”. So here a more robust patient input is advocated.

I have recently returned to teaching at University. It reminds me that teaching, is not just about imparting information to someone and expecting him or her to understand what you have said. This student/teacher model can be transferred to the patient care and HCP interaction model. This model can be further transposed to the shared decision-making aspect of patient/clinician interaction. I suggest that HCP’s should use the elements used in teaching of Pastoral care to students in order to obtain a superior patient/HCP interaction outcome. Pastoral care is an ancient model of emotional and spiritual support that can be found in all cultures and traditions. It has been described in our modern-day context as “individual and corporate patience” in which trained pastoral carers support people in their pain, loss, anxiety, their triumphs, joys and victories. This form of interaction and ethos is not exclusive to teaching and is clearly used elsewhere such as human resources, and the patient/HCP interaction.

When I first qualified and taught as a teacher in the secondary education system in the UK in 1990, a definitive lack of pastoral care elements were not taught that would have gone a long way to helping a large group of students that were excluded from mainstream schools due to their behaviour. Instead, this group of students were simply written off as disruptive to the main body of students and to ensure the best educational environment for the main body, they were excluded. This group of students would now be called special needs students. During my recent and brief time volunteer working with the Catch 22 charity, here in London, prior to commencing my lecturing role at the University, I immediately noticed that the young people I would see arriving at the Hive centre, where I was based, were almost exclusively the students that would have been previously excluded as being disruptive students that I saw in 1990. It is wonderful to see these individuals have a venue where they can relax and engage and be engaged. The majority have one to one sessions with social workers. These sessions help them confront and come to terms with, in some cases, very difficult home backgrounds on top of their own various mental health issues and in some cases, these issues are combined with problematic physical conditions.

The school’s remit is to have inclusion, equality and diversity of all. From my interactions and discussions with these young people, it seems that their schools still do not necessarily have full inclusion. This however may be due more to the nature and tendency of young people to marginalize individuals that do not fall into the mainstream of physical and emotional/mental capabilities rather than the institutional failings. The institutions however have a duty to these individuals to make the environment inclusive. From my interaction with these

special needs young people at the Hive, I now have a new understating of them and see how poor the training was, that we as teachers received at the time. Quite a number of these special needs young people that I saw at the Hive have autism, learning difficulties, social interaction problems and behavioral problems. These are brought on by a plethora of reasons.

Whilst at the Hive, some of the young people that I engaged in conversation would ask me “how my weekend was and what did I do”? I told them what I did, and they replied, “So you didn’t do (they would say a few different activities)”? I said, “I didn’t do those things as I didn’t have time to”, but in reality, I never had that conversation with them where they cited certain activities. That is when I decided to ask the full-time staff and case managers if the young persons in question had some form of learning difficulty, e.g. dyslexia. They replied they did. A common trait amongst dyslexics is poor memory and confusing conversations had with different people and catastrophising an encounter.

I have since added the question “are you dyslexic”? to my initial contact session with patients during my subjective examination with them. Why do this? My research into dyslexics after working with the young people at the Catch 22 charity, has shown that they have certain common traits that warrant the inclusion of such a question. The following are common traits that dyslexics have. These traits have been derived from evidenced based research and can also be found on the British Dyslexic society web pages:

LoGiudice, 2008 [11]

- Has difficulty focusing and staying on task – may feel more comfortable managing many different tasks simultaneously
- Easily distracted/annoyed by noises and other things in environment.
- May appear to “zone out” and be unaware that it is happening.
- May confuse past conversations or be accused of “not listening”.
- Difficulty remembering verbal instructions or directions.
- Poor recall of conversations or sequence of events.
- May have a short fuse or is easily frustrated, angered, or annoyed.
- Easily stressed and overwhelmed in certain situations.
- Confusion, stress, physical health issues, time pressure, and fatigue will significantly increase symptoms.

Davis, 1994 [12]

- Confused by letters, numbers, words, sequences, or verbal explanations.
- Has extended hearing; hears things not said or apparent to others; easily distracted by sounds.
- Has difficulty telling time, managing time, learning sequenced information or tasks.
- Mistakes and symptoms increase dramatically with confusion, time pressure, emotional stress, or poor health.

This knowledge has helped me understand what a failing the educational system had when dealing with these students back in the 1990’s, that could have been avoided if the current system of teaching assistants within the class as is seen now would have been adopted. They sit next to these individuals and explain and assist in their class work. This allows the individual to remain in the mainstream schooling system and normalizes their experience and behavior rather than marginalizing them to “special” institutions. Exclusion of these students led to large dropout rates of attendance by these individuals that saw themselves as misfits.

The medical teaching institutions should adopt this idea and ideals. Not so much the “teaching assistant” model, but the pastoral element, with an additional insight for individuals that have these “special requirements” of learning difficulties such as autism, dyslexia etc. and what the ramifications are for the patient/medical practitioner interaction. The most obvious outcome is that these individuals can possibly catastrophize the encounter [3-10] with the medical practitioner and end up with a worsened perceived condition irrespective of what occurred during the appointment.

I commenced this piece, stating that HCPs should view the patient more holistically. One way of doing this is by looking at the psychosocial components that inherently we all have not just patients that seek medical advice/interaction. The flag system was first posited by Kendal [13]. It was introduced in order to help the clinician in avoiding possible errors and conflicts with the aforementioned “special” patient group. Flags can be split into two distinct categories: clinical flags and psychosocial flags [13 & 13a].

Clinical flags are common to many areas of health – for example, red flags for musculoskeletal disorders, which are indicators of possible serious pathology such as inflammatory or neurological conditions, structural musculoskeletal damage or disorders, circulatory problems, suspected infections, tumours or systemic disease. If suspected, these require urgent further investigation and often surgical referral.

There are certain signs and symptoms that when observed in a patient’s examination or history alert us to the fact that something could be seriously wrong. In the case of musculoskeletal disorders, physiotherapists are highly trained to identify or rule out red flags. If you suspect any red flags the patient must seek urgent medical attention and it is better to send the patient to accident and emergency rather than risk any permanent, life changing pathology.

Recently, orange flags were added to the spectrum and represent the equivalent of red flags for mental health and psychological problems, alerting the clinician to serious problems that could be psychiatric in nature, and therefore require referral to a specialist in that field, rather than following the normal course of management for mild mental health conditions such as anxiety. Orange flags can include excessively high levels of distress, major personality disorders, post-traumatic

stress disorders, drug and alcohol abuse/addictions or clinical depression.

Psychosocial flags allow us to identify aspects of the person, their problem and their social context, and how those factors affect the recovery and return-to-work process. This flag concept looked at factors that identified patients who were at risk of developing chronic disability and did not recover as was expected for their condition.

Psychosocial flags enable us to work from a biopsychosocial model and give a framework for assessment and planning. These flags are not a diagnostic of symptoms, but an indication that someone may not recover as expected and may need additional support to return to work. These flags are often referred to as obstacles to recovery. Psychosocial factors determine outcomes such as activity levels and participation and work but appear to be less relevant to the reporting of symptoms.

Psychosocial flags

Psychosocial flags have been subdivided over the years to reflect the different interactions that can affect recovery. As a result, they are now referred to as yellow, blue and black flags. Briefly, **yellow flags** cover the features of the person which affect how they manage their situation with regard to thoughts, feelings and behaviours. **Blue flags** concern the workplace and the employee's perceptions of health and work. **Black flags** are about the context and environment in which that person functions, which includes other people, systems and policies. Black flags can block or limit the helpful activity of healthcare providers and workplace support.

Below is a table with some examples of a flag colour, the nature of the flag and examples of clinical signs to look for on assessment:

Flag	Nature	Examples
Red	Signs of serious pathology	Cauda equina syndrome, fracture, tumour, unremitting night pain, sudden weight loss of 10pounds over 3 months, bladder & bowel incontinence, previous history of cancer, saddle anaesthesia.
Orange	Psychiatric symptoms	Clinical depression, personality disorder
Yellow	Beliefs, appraisals and judgements	Unhelpful beliefs about pain: indication of injury as uncontrollable or likely to worsen. Expectations of poor treatment outcome, delayed return to work.
	Emotional Responses	Distress not meeting criteria for diagnosis of mental disorder. Worry, fears, anxiety.
	Pain behaviour (including pain and coping strategies)	Avoidance of activities due to expectations of pain and possible reinjury. Over-reliance on passive treatments.
Blue	Perceptions about the relationship between work and health	Belief that work is too onerous and likely to cause further injury. Belief that workplace supervisor and workmates are unsupportive.
Black	System or contextual obstacles	Legislation restricting options for return to work. Conflict with insurance staff over injury claim. Overly solicitous family and health care providers. Heavy work, with little opportunity to modify duties.

Figure 1: Kendal et al

Orange Flags

Screening for orange flags is performed by asking questions regarding clinical depression or other personality disorders. Screening for clinical depression is completed with the Patient Health Questionnaire-2 (PHQ-2 [13b]). The purpose of the PHQ-2 is not to diagnose depression, but rather screen for it

in a “first-step” approach. Validity has been assessed against an independent structured mental health professional (MHP) interview. PHQ-9 score ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression. It can even be used over the telephone. The following are its constituent questions.

PHQ-2 part

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed or hopeless

Answers: 0-Not at all, 1-Several days, 2-More than half the days, 3-Nearly every day

Scoring: 0 points for “Not at all” answer, 1 point for “several days”, 2 points for “more than half the days”, and 3 points for “nearly every day. The cutoff score for screening purposes is 3. If the individual scores >3 , one must continue with the PHQ-9 form for further assessment of depression. I have now adopted the PHQ2/9 into my initial assessment, first contact appointment session questioning of the patients’ past medical history and history of current condition profiling. This is a very quick and clinically proven way to get a patient baseline for their psychosocial status. I will write the scores from the PHQ2/9 in the notes under special questions (SQ). The SQ were already part of my note taking practice, but I had exclusively kept this section for the msk flags. I will add the moniker of PHQ2 and the score. If the score exceeds 3 then the aforementioned (and continued below) psychosocial flags will come into play. If a PHQ2 score of >3 is achieved, then the PHQ9 form seen below will be employed by myself to further score the patient.

Pain Questionnaire

Nine “yellow flag” questions to ask your patients with back pain
(the term “back pain” includes neck pain)

Thinking about the last 2 weeks tick your response to the following questions:		Agree 1	Disagree 0
1. My pain has spread to other areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My pain has got worse since the onset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have been walking shorter distances recently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I find I am dressing more slowly than usual because of pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. It's not really safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Worrying thoughts have been going through my mind a lot of the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I feel that my back pain is terrible and it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Since the start of this pain I have not been able to enjoy things as before	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Overall, how bothersome has your back pain been in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Not at all Slightly Moderately Very much Extremely

 0 0 0 1 1

Total Score (all 9): _____ Sub Score (Q5-9): _____

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If the Total Score is 4 or more AND the Sub Score is 4 or more it is recommended that the patient is referred for an assessment to determine their suitability for a Functional Restoration Programme

Figure 2: PHQ9

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
 Several days (#) _____ x 1 = _____
 More than half the days (#) _____ x 2 = _____
 Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website
www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Yellow flags

Obstacles that can be classed as yellow flags include many aspects of thoughts, feelings and behaviours. Some common examples include:

- Catastrophising – thinking the worst
- Finding painful experiences unbearable, reporting extreme pain disproportionate to the condition
- Having unhelpful beliefs about pain and work – for instance, ‘if I go back to work my pain will get worse’
- Becoming preoccupied with health, over-anxious, distressed and low in mood
- Fear of movement and of re-injury
- Uncertainty about what the future holds
- Changes in behaviour or recurring behaviours
- Expecting other people or interventions to solve the problems (being passive in the process) and serial visits to various practitioners for help with no improvement.

Blue flags

Blue flags can be considered in terms of the employee and the workplace. The employee often has fears and misconceptions about work and health based on their own previous experiences or those of others in the company they work for, or stories from the neighbours. Blue flags can include:

- Concerns about whether the person is able to meet the demands of the job
- Low job satisfaction
- Little or poor support at work
- A perception that the job is very stressful
- An accommodating approach in the workplace to providing altered duties or modified work options to facilitate a return to work

- Poor communication between employer and employee.

Black flags

There is some overlap between blue and black flags, but they can be primarily distinguished by the black flags being those that are outside the immediate control of the employee and/or the team trying to facilitate the return to work. Black flags include:

- Misunderstandings among those involved
- Financial issues and/or claims procedures
- Sensationalist media reports
- Family and friends with strong unhelpful beliefs influencing the employee
- Social isolation and becoming disconnected from the workforce

Poor or unhelpful company policies. Often company policies can take two forms: either there is no policy or inadequate policy surrounding sickness absence management and return to work, or there is rigid management of absence within a disciplinary policy system that does not allow sufficient flexibility to deal with genuine injury and illness rehabilitation needs.

Flag Assessment

So how does one assess psychosocial flags? The literature recommends an early intervention and stepped approach to common health problems. It is believed that psychosocial factors start to become increasingly important between two and six weeks of onset of the problem, and assessment can begin during this period.

A stepped approach means using an assessment tool as

appropriate for the needs of the employee. This can take the form of asking some key questions and undertaking a screening questionnaire, and then making further in-depth assessment where indicated by these processes.

There are several useful methods for assessing flags:

Observation of the way the employee behaves, interacts with others, and talks about their condition and work. These will give one an idea of the flags that may be present. Useful questions that Gray and Howe devised [14] include:

- What do you think has caused the problem?
- What do you expect is going to happen?
- How are you coping with things?
- Is it getting you down?
- When do you think you'll get back to work?
- What can be done at work to help?

Structured interview

If the methods above have confirmed the presence of flags, then the structured interview is the next step in obtaining more information about particular issues and flags. An acronym has been developed to help remember which areas to ask more about: ABCDEFW.

- Attitudes/Beliefs – What does the patient think to be the problem, and do they have a positive or negative attitude to the pain and potential treatment?
- Behaviour – Has the patient changed their behaviour to the pain? Have they reduced activity or compensating for certain movements? Early signs of catastrophising and fear-avoidance?
- Compensation – Are they awaiting a claim due to a potential accident? Is this placing unnecessary stress on their life?
- Diagnosis/Treatment – Has the language that has been used had an effect on patient thoughts? Have they had previous treatment for the pain before, and was there a conflicting diagnosis? This could cause the patient to over-think the issue, leading to catastrophising and fear-avoidance.
- Emotions – Does the patient have any underlying emotional issues that could lead to an increased potential for chronic pain? Collect a thorough background on their psychological history.
- Family – How are the patient's family reacting to their injury? Are they being under-supportive or over-supportive, both of which can effect the patient's concept of their pain
- Work – Are they currently off work? Financial issues could potentially arise? What are the patient's thoughts about their working environment?

The conclusion of researchers and working group members at the 'Decade of the Flags' conference in 2009 [13c], suggest that there are seven key workplace factors that are important to include in screening, and cited helpful sample questions:

1. Heavy physical demands: Are you concerned that the physical demands of your job might delay your return to work?

2. Inability to modify work: Do you expect your work could be modified temporarily so you could return to work sooner?
3. Stressful work demands: Are there stressful elements to your job that might be difficult when you first return to work?
4. Lack of workplace social support: What kind of response do you expect from co-workers and supervisors when you return?
5. Job dissatisfaction: Is this a job you would recommend to a friend?
6. Poor expectation of recovery and return to work: Are you concerned that returning to your work may be difficult given your current circumstances?
7. Fear of re-injury: Are you worried about any repeat episodes of (back) pain once you return to work?

A visit to the workplace is an excellent additional method of assessing flags. Whether an informal visit or a more structured one for ergonomic assessment, a wealth of information can be gathered when you are familiar with the flags system and what to look out for.

It is appropriate at this juncture to discuss a group of patients that form the largest part of the CPP cohort globally. The biggest reason for missed days from work in the world is that of spinal pain [13d]. This study found that "low back pain is now the leading cause of disability worldwide". In many this will become a chronic issue and the individual will become a CPP. The aforementioned PHQ2 and 9 questionnaire will give a psychometric factor for the individual. A tool that will consistently give the HCP a factor for the physical pain and impediment to an individual should also be employed. This will further formalize the construct of patient assessment, resulting in better outcomes. I employ the Keele star system (2007) with my spinal pain patients. This is seen below.

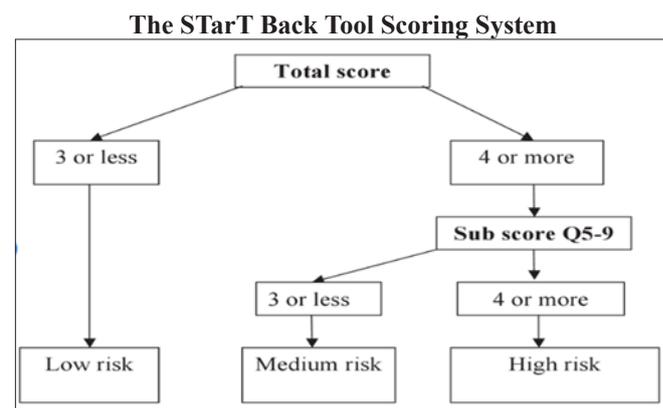


Figure 3: Taken from Keele University 1-8-07

Unfortunately, I am not alone within the world of healthcare when it comes to not always considering the flag system of psychosocial parameters and to only focus on the physical red flag (msk) aspect of a patient complaint. This is supported by various authors [13-15]. From this group of cited authors, Gray & Howe 2016 [13a] concluded that "The findings of this systematic review would suggest that significant

barriers remain to the integration of psychosocial factors into physiotherapy practice; therefore, it is still not the 'cultural norm' for physiotherapists to engage in the assessment and management of psychosocial factors in rehabilitating individuals with back pain. The implication of this will have a subsequent detrimental effect on patient treatment outcome". Therefore, the review authors are putting out a call to action for physiotherapists to embrace the importance of integrating psychosocial factors into their everyday professional practice. In particular, physiotherapists need to gain confidence in tackling Blue Flags as this is critical to establishing themselves as essential players in combating industrialized society's rising public health concern of worklessness".

Image 1 below demonstrates how physiotherapists in the UK are still struggling with the flag system concept despite its original presentation 22 years prior to the query raised in image1. As can be seen in Image 1, the query made on the Chartered society of Physiotherapy (CSP) forum regarding the flag system and how to implement it during the patient session (query date = 10-7-19) is still up for debate. On the online forum that the query was taken from, other practitioners kindly suggest other methods and strategies (e.g. the EQ-5D (EQ-5D-5L). The EQ-5D is a generic instrument for describing and evaluating health and was first outlined in 1990. It was designed by the EuroQol Group. This group was initially formed in 1987 with the researchers of multidisciplinary areas from five European countries; Netherlands, UK, Sweden, Finland, and Norway. It is based on a descriptive system that defines health in terms of 5 dimensions: Mobility, Self-Care, Usual Activities, Pain/Discomfort, and Anxiety/Depression. Each dimension has 3 response categories corresponding to no problems, some problems, and extreme problems. The instrument is designed for self-completion, and respondents also rate their overall health on the day of the interview on a 0–100 hash-marked, vertical visual analogue scale (EQ-VAS). The EQ-5D was designed to measure decrements in health. Substantial use of the instrument has shown that it can suffer from ceiling effects, particularly when used in general population surveys but also in some patient population settings. As a result, there may be issues regarding its ability to measure small changes in health, especially in patients with milder conditions. In light of these possible limitations, and stimulated by demand from the clinical field, the EuroQol Group decided to explore ways of improving the EQ-5D's measurement properties. The Chartered Society of Physiotherapy in the UK used to advocate the use of this system and used to provide the template free of charge. With the advent of more triage systems it is no longer recommended but used as an example of a readily available system of triage.

Although a seemingly valid and current system, it highlights how the waters are muddied by a non-uniform assessment yardstick being used across the healthcare professions. It again highlights how many practitioners have not been considering this further overlay in their assessment and how situations such as mine can arise when not considering all aspects of the patient/ clinician interaction. Ultimately considering all

aspects will ultimately lead to a better patient experience and therefore time must be made for such assessments.



I will now introduce you to the concept of **Transactional analysis (TA)** (developed by Dr Eric Berne 1961 [15a]). This is an alternative philosophy that one can adopt when interacting with patients. It is a psychoanalytic theory and method of therapy wherein social transactions are analyzed to determine the ego state of the patient (whether parent-like, childlike, or adult-like) as a basis for understanding behavior. In TA, the patient is taught to alter the ego state as a way to solve emotional problems. I find this construct interesting as we can all identify within our own peer group, individuals that fall into one or another of the 3 ego states and often an individual can traverse them all depending on the setting, i.e. a childlike ego may prevail when a female/male is out with her/his group of exclusively female/male friends and there is a tendency for frivolity. This is therefore the childlike ego and will be most suited to this scenario than the more serious adult like ego. The problem is the TA theory postulates that we are one or the other. The method derives from the 1923 Freudian psychoanalysis theory, which focuses on increasing awareness of the contents of unconsciously held ideas.

With its focus on transactions, TA shifted the attention from internal psychological dynamics to the dynamics contained in people's interactions. Rather than believing that increasing awareness of the contents of unconsciously held ideas was the therapeutic path, TA concentrated on the content of people's interactions with each other. Changing these interactions was TA's path to solving emotional problems. Berne considered how individuals interact with one another, and how the ego states affect each set of transactions. Unproductive or counterproductive transactions were considered to be signs of ego state problems. Analysing, these transactions according to the person's individual developmental history would enable the person to "get better". Berne thought that virtually everyone has something problematic about his or her ego states and that negative behaviour would not be addressed by "treating" only the problematic individual.

This idea is then used in conjunction with the drama triangle: It is a social model of human interaction – the triangle maps a type of destructive interaction that can occur between

people in conflict. The drama triangle model is a tool used in psychotherapy, specifically TA. S.B. Karpman (a medical Doctor in 1968 [16] used triangles to map conflicted or drama-intense relationship transactions. The Karpman Drama Triangle models the connection between personal responsibility and power in conflicts, and the destructive and shifting roles people play. He defined three roles in the conflict: Persecutor, Rescuer (the one up positions) and Victim (one down position). Karpman placed these three roles on an inverted triangle and referred to them as being the three aspects or faces of drama.

- 1. The Victim:** The Victim's stance is "*Poor me!*" The Victim feels victimized, oppressed, helpless, hopeless, powerless, ashamed, and seems unable to make decisions, solve problems, take pleasure in life, or achieve insight. The Victim, if not being persecuted, will seek out a Persecutor and also a Rescuer who will save the day but also perpetuate the Victim's negative feelings. In this instance it could be a patient that has had an health complaint that has not been resolved despite attending various other HCP's in an attempt to help with their condition.
- 2. The Rescuer:** The rescuer's line is "Let me help you." A classic enabler, the Rescuer feels guilty if they don't go to the rescue (i.e. most HCP's). Yet their rescuing has negative effects: It keeps the Victim dependent and gives the Victim permission to fail. The rewards derived from this rescue role are that the focus is taken off of the rescuer. When they focus their energy on someone else, it enables them to ignore their own anxiety and issues. This rescue role is also pivotal because their actual primary interest is really an avoidance of their own problems disguised as concern for the victim's needs.
- 3. The Persecutor:** (a.k.a. Villain) The Persecutor insists, "*It's all your fault.*" The Persecutor is controlling, blaming, critical, oppressive, angry, authoritative, rigid, and superior. This could be a disgruntled patient that is unhappy with their treatment outcome or even the HCP's regulatory body that has taken up the patient complaint to a tribunal stage.

The assumption a clinician makes when a patient comes to see them for their condition is that (if of adult age) they are an adult, with an adult ego as they have taken it upon themselves to make the appointment to see the HCP for help in recognition of their health condition. The average sessions are too short to put all these systems into practice. Typically, the NHS gives a 20-minute physiotherapy appointments slot. Private clinics, due to the fee capping of all insurance companies, also typically offer 20 minutes follow up appointments after an initial 30 minutes appointment, with the occasional exceptional 45 minute initial appointment being offered but at higher prices. This, again, highlights why and how errors can occur when judging a patient erroneously on the flag system due to time constraints.

From the aforementioned it is clear there are several assessment systems that can be used. There is no one system that fits all, and perhaps this is the problem. Different practitioners will

adopt different systems and as such, cross familiarity with all the systems may not be known to individual practitioners. This may be an issue when notes are sent across between clinicians, for continuing treatment, when a patient moves out of an area due to work etc. and will inevitably lead to differential scores being attributed to the patient from different practitioners.

Conclusion

In conclusion, I am categorically not stating that a patient will make a formal complaint due to them being a chronic pain patient and or having a learning disability such as dyslexia. What I am saying is, that these are very real issues that can occur and are often seen in the healthcare system, and as such it will always produce complaints irrespective of how the patient/clinician interaction is conducted. It is our duty as clinicians to be wary of this and always provide the best service possible.

This notwithstanding, it can be argued that all patients going to see a clinician when not content with the outcome can have any of the aforementioned psychological traits if not all. However, it can also be said the clinician can also have said traits. A counterpoint argument, can be that, a clinician that has been in practice for decades with no complaints having been made against them is either "a", able to apply the aforementioned techniques alongside their therapy, either innately or post training in such matters, or "b", that they will not be able to identify individuals that fall under these headings irrespective of their training, and a negative outcome for the patient and clinician will arise. This is a most interesting point due to the nature of psychology and the myriad of variants that present within us all.

Based on this postulation, it is clear clinicians will sooner or later fall foul of a patient complaint deserved or not. The latter is of most concern. Most clinicians, and certainly the regulatory tribunal services that then sit in judgement of such matters do not think to address this possible element within the interaction that led to the complaint. This was certainly the case in my instance. By not having explored the area of dyslexia and all its ramifications as cited above I fell afoul of a patient complaint to my regulatory body. It must be said at this time that I was not aware of the dyslexic element with the patient and only became aware of it at the hearing. If I had used the psychosocial flag system and extra special questions (re learning disabilities), then the dyslexia would have been picked up at the onset of the appointment.

It is clear most clinicians (apart from the psychologists and psychiatrists) lack this aspect in their training and the dynamic of interaction between the clinician and patient will in some cases end with one of the aforementioned scenarios be it "perceived injustice" [3] that leads to "catastrophising" [3], varying "ego states" [15a] or standing on one side of the "drama triangle" [16].

Through this experience I have learned that I have not been looking holistically enough at the patient that comes to see me. Previously I have examined what is the patient's problem? (i.e. origin, aetiology, disability, pain, historical background

etc.). How do I fix this and how to fit the rehab/healing/treatment in with the person's lifestyle? I failed to assess what the psychological status of the patient is, not only in this instance, but in general, it had not been a consideration of mine. I assume all patients are highly motivated and want to get better. I believe this is certainly the case in the vast majority of individuals, but some will not meet this standard and as such the alternative strategies as presented above need to be employed. Some patients however, understandably, become frustrated with the process. This frustration tendency is recognised within the NHS and that is why all chronic pain individuals that are seen in the NHS are offered counselling sessions alongside their medical intervention. This is as a result of the increasing amounts of complaints made against the NHS. The BBC published an article in 2020 stating the NHS has 4.3 billion pounds to payout in claims against it and see over 10000 claims against it yearly (<https://www.bbc.co.uk/news/health-51180944>).

Recognising the aforementioned theories as being a contributing factor of why some patients with chronic pain do not get better and in many instances worsen is important for any clinician to consider. This is irrespective of the progressive or non-progressive deterioration of the patient's condition, and in many instances these individuals will "catastrophise their encounter with a clinician" [3].

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