# Skillful Physician Communication

Master the Communication Skills of a Compassionate Patient-Experience

Based on the HCAHPS Breakthrough Series

Brian Lee CSP
*with* David Dworski

# Reviews for Skillful Physician & Medical Provider Communication

"Over the last four decades practicing medicine I have often contemplated what is the essence of health care. I have concluded that our calling and profession is about caring and competence. I have also found that if patients perceive you care, competence is presumed. As you journey through the pages of this book you will discover many skills and tools that will enhance compassionate communication with your patients and co-professionals. Aside from the positive impact this will have on your patients' health, I believe you will find increasing satisfaction and joy in your practice of medicine."

– Michael A Klein, MD, CMO

"This book is geared to improve patient perceptions of care in connection with the mandated CMS HCAHPS surveys but much more. All physicians and healthcare providers can embrace the caring practices illustrated in this text to assist them in their patient care in hospitals and office practices."

– Phyllis Van Crombrugghe, CNO

"Medicine is the science, the technique that must be taught with the humanistic example of who we are and how we wish to be treated, to each and everyone who have the opportunity and the privilege of having a patient in front. This great piece of medical literature gives us the chance to understand the challenges and huge responsibility of humanistic physician communication and behavior. It opens the door to resume the most basic, but difficult skills to empathize with our environment and patients."

– Jorge Garcia De la Rosa M.D.

Brian Lee

# Skillful Physician & Medical Provider Communication

**To provide Clinical excellence and a compassionate patient experience**

**Lee, Brian**

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# Skillful Physician & Medical Provider Communication

BRIAN LEE

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# Foreword

This book came into being in order to provide timely and significant information about how physicians and healthcare providers can improve their communication with patients. Patients and doctors agree that the need to develop effective communication with patients is essential to compassionate care and positive healthcare outcomes. As will be explored, it is necessary for healthcare professionals to develop communication habits of investing in the beginning and end of the patient encounter, eliciting patient's perceptions of their health issues and demonstrating empathy.

As physicians and healthcare providers become more adept at their communication interactions, they reduce burnout, increase their own job satisfaction and hardwire positive patient experiences.

HCAHPS *(Hospital Consumer Assessment of Healthcare Providers and Systems)* surveys areas of clinical competence called

"Domains." One of these is "Communication with Doctors." This text is an extensive review of the critical elements of doctor-patient communication.

The reader will benefit by implementing the communication guidelines proven to increase patient satisfaction. It is our passionate belief that communication is crucial to promoting a positive, caring atmosphere, enhancing compliance, preventing misunderstandings and leads to more accurate diagnoses and treatment plans. (JACHO reports that 60% of sentinel events are due to poor communication.)

We hope readers will connect with this information and refer to this book periodically to keep their communication sharp. Our patients deserve our very best efforts to be effective compassionate communicators.

CHAPTER 1

# Master the Communication Skills of a Compassionate Patient Experience

Most of us think physicians are very special people. They are amazing, and work in a wonderful profession that we will all experience in our lives. The training doctors must undergo is rigorous almost beyond belief. Their work ethic is nothing short of extraordinary. We admire their skill and dedication.

We share their vision to provide clinical excellence.

Questions to begin our thinking about compassionate communication:

- Is patient satisfaction important?
- Do we have to sacrifice patient satisfaction for the sake of efficiency and productivity?
- Can healthcare providers improve their communication skills with their patients?

This text is dedicated to those healthcare providers who are serious about improving their communication with patients. It is important, and no, we don't have to sacrifice patient satisfaction for the sake of efficiency.

As a patient, have you ever felt that communication between doctors/providers and patients is somehow lacking? Have you ever left a clinical situation dissatisfied, with the nagging feeling that you weren't listened to? Or worse: that you didn't understand what the doctor told you about your health?

If you've ever had these feelings, you are not alone… unfortunately, these patient experiences are all too common. This is borne out by several patient follow-up surveys.

Recently, a retired physician, (we'll call him Dr. Richards), was reminiscing about his early days in practice. He pointed out that he had to learn many lessons that were not covered in his formal medical training. One such lesson was that he had to learn to be patient with people, and not be too hasty in his diagnoses or discussions with patients. Furthermore, he had to learn to really listen to his patient's concerns and be very clear when communicating to them.

Patients need to share their story, their worries and symptoms in their own way. When they're allowed to do this, they feel heard the first time and don't need to repeat themselves or seek a second opinion because they felt ignored. They don't become irritated or dissatisfied. "Yes," said Dr. Richards, "We have to learn to balance efficiency with thoroughness." As in so many interactions, the key is how we communicate to our patients. This is the greatest tool of patient care, and it isn't always easy. Learning to speak to patients their way requires a determined and consistent effort.

William Osler, MD *(1849-1919*), sometimes called the father of modern medicine, said "The good physician treats the disease, the great physician treats the patient who has the disease."

Our mission in this text is how to analyze doctor-patient interactions and recommend guidelines to develop skillful communication for physicians/providers. This is part of the **H.O.P.E.** *(Hardwiring Our Patient's Experience) Plan.*

For the compassionate experience to be successful, there are four habits Physicians must strive to acquire. ("Habits" are organized ways of thinking and acting during clinical encounters. Frankel and Stein, 1998.) The habits are:

- Invest in the beginning of the patient encounter.
- Shake hands
- Elicit the patient's perceptions of their condition.
- Demonstrate empathy.
- Invest in the end of the encounter

1 **Invest in the beginning.** Quickly review the patient's chart before the encounter, and greet the patient by name when entering. Use this technique: *"Would you be comfortable if I use your first name or would you like me to use the more formal, Mr., Mrs., or Ms.?* Or ask: *"How would you like to be addressed?"* This shows respect, offers the patient some control and establishes a partnering communication. Then put the patient's preference on the white board.

2 **When entering, shaking hands denotes a certain egalitarianism.** Let the patient know you are familiar with their case. *"I've reviewed your record and would like to discuss several issues with you."* If need be, apologize if they have been kept waiting. Be seated. Use open- ended questions to elicit their concerns and determine how aware they are of their condition. *"Tell me about how you're feeling."* Use emphatic responses such as head nods and "uh huhs" to indicate that you are listening. (We'll discuss much more about listening later.) These are common sense issues, but they are important and often neglected.

3 **Elicit the patient's perspective.** The focus here is understanding the impact the symptoms have on the patient. Again, using open-ended questions is extremely useful. *"What worries you the most?" "How is this affecting your life style, work or family?"* Probing the patient's perspective shows respect, caring and helps gather clinical data. Encourage the patient to describe their condition, their way. *"Tell me in your own words…"* This approach respects diversity and often uncovers hidden concerns, especially as they relate to the patient's anxieties. In addition, it is helpful to assess the patient's expectations regarding etiology and

expectations. Discovering the full spectrum of the patient's concerns affects their compliance. According to Froelich and Welch, and other studies, 40-80% of patients who receive recommendations do not follow them. Knowing the patient's perspectives will mitigate against their lack of follow up.

4 **Demonstrate empathy.** Putting yourself in the patient's place. Try to see their concerns from their point of view. Empathy joins the patient and the physician in a shared understanding of the patient's experience. Empathy means being open to the patient's feelings. *"I can understand how you could feel this way." "I can see how distressing this is to you."*

### *Pro Tip*

Do not use the word, "exactly" when empathizing. As in, *"I know exactly how you feel."* First, it is nearly impossible to know *exactly* how another person is feeling. Secondly, the "exactly" comment often elicits a, *"No, you don't,"* response from the patient. Sometimes the physician's concerns for efficiency and time management can act as a barrier to using empathy. Stuart et. al. showed that physicians who demonstrated sensitivity to patient's emotional concerns took approximately one minute longer in patient encounters that physicians who do not (University of Western Ontario, 1989). Paraphrasing also helps with empathy. *"You indicated that you were worried about…" "If I understood you correctly, you felt your pain increased with movement."*

5 **Invest in the end.** The first three habits deal with gathering information. The fourth habit is concerned with dispensing information, teaching and participating with the patient in decision making. Explaining the diagnoses, test results, procedures, and course of treatment in terms the patient can understand is critical to compassionate communication and compliance. Patients naturally want to know what is causing their symptoms and what can be done to relieve them of their pain or discomfort. Using the patient's expressed concerns gleaned from habit # 2 provides a guide to explaining their condition. "You said that the pain was intermittent and caused numbness in your fingers. Our tests indicate a carpel tunnel problem which explains your symptoms and gives us a clear course of action to relieve your problem." Remember that once a patient has heard a diagnosis, especially if the news is bad, the patient doesn't listen well because their emotions interfere with their comprehension. It is extremely important to check the patient's understanding of what has been discussed. Also, patient participation in decision-making is essential to positive functions and biomedical outcomes. Always finish your interview by asking if there are any further questions or concerns. Finally, offer reassurance of ongoing care.

Consider that physicians conduct over 120,000 patient interviews during their clinical practice. Improvements in compassionate communication during these interviews greatly affect positive healthcare outcomes!

Patients are less concerned with how much their physicians know, than how much they care.

The goals in establishing these compassionate communication habits are to: establish rapport, build trust, facilitate the exchange of information, demonstrate concern and ensure compliance. Cultivation of these habits contributes to physician satisfaction and reduces burnout.

**A word about "burnout."**

Although many Americans think physicians have it made, the reality is quite different. The pressures and time constraints are tremendous. Physicians have a high suicide rate, have more trouble with addictions, divorce more frequently and often feel overwhelmed.

A 2012 study of 5000 physicians showed that 89% would not recommend medicine as a profession to their children. 52% of physicians over the age of 50 plan to leave the profession within 5 years. One solution is to lessen the de-personalization and exhaustion so many physicians feel. (John Puma, MD Physician August 2014.)

***Recommendations:***

1. Take a few moments to review the patient's chart or records before the encounter.
2. Use open-ended questions to allow the patient to explain their condition, their way. Listen carefully.

***Continued...***

## *Recommendations:*

3. Make empathetic responses during the interview.
4. Explain information about their condition in terms they can understand.
5. Involve them in decision-making.

CHAPTER 2

# Medical Provider Questions

HCAHPS stands for Hospital Consumer Assessment of Healthcare Providers and Systems. It's a survey of clinical performance on a scale from 1 ("never") to 4 ("always"). The areas surveyed are called "domains" – this text is concerned with the "Communication with Doctors" domain.

Three survey questions are asked of patients regarding doctor communication:

**Survey Question #1:** *During your hospital stay, how often did doctors treat you with courtesy and respect?*

**Survey Question #2:** *During your hospital stay, how often did doctors listen carefully to you?*

**Survey Question #3***:* *During your hospital stay, how often did doctors explain things in a way that you could understand?*

Recently, the national average of patients responding with a "4" (meaning "always"), was 79.4%. Compare that with your facility scores on these questions. How did you compare?

**Something to Remember:**

*Questions stimulate thinking*. This is the reason the HCAHPS Inpatient Survey has 31 questions.

It is beneficial to consider questions that patients typically are asking themselves.

**Examples:**

- What should I expect from my doctor?
- How can I explain my symptoms?
- What's going to happen next?
- What do their tests show?
- How long will I be here?
- Why do I feel this way?
- What should we be asking ourselves as healthcare providers about our communication?

If we know that most patients are asking themselves these types of questions, what questions must we ask ourselves in response?

**Examples:**

- How can I best put this patient at ease?
- How can I best establish rapport?
- How can I be more empathetic?
- How can I hone my listening skills?
- Have I explained things in a way that my patient understands?
- Have I opened the doors for the patient to ask me questions?

Since we know the test questions, wouldn't it be a good idea to master the answers?

CHAPTER 3

# Why Compassionate Provider Communication Matters

Let's examine the three notions above:

- What is entailed in courtesy and respect?
- What are the key attributes in listening effectively?
- And how can we explain things more satisfactorily?

The first question relates to old fashioned manners. Can we remember how we were taught manners? Most of us would like to return to those days. What do you think of the manners of people younger than yourself? How about the manners of healthcare providers?

The domain of **Communication with Doctors** is, as the name suggests, designed for medical professionals interacting with patients (including hospital leadership, key medical staff, all doctors, mid-levels, hospitalists, PA's and providers of all kinds).

We like to refer to treating the patients with courtesy and respect as "compassionate communication." *Why is this important?*

It matters because

1. It provides an atmosphere of loving kindness.
2. It creates loyalty.
3. It enhances compliance.
4. It prevents problems and lawsuits.

Let's examine each of these elements in turn:

When compassion is shown through communication, a "loving kindness" occurs. This affirms and honors a core of goodness in others and in oneself. The Dalai Lama said, "*My religion is kindness."* It's not that hard to be kind.

Joanna raved about the care that her elderly mother received from her doctors. (There were several doctors involved in her treatment.) Her positive impressions were all about the gentleness and kindness shown by each of the physicians. *"They spoke to her and us with respect and never talked over my mother."* Joanne couldn't evaluate the competence of the doctors, but she sure could judge their manner.

"Loyalty" enables the patient to relate to critical information more readily, which leads to more accurate diagnoses and

treatment plans. Loyalty ensures compliance with medication, therapy and follow up procedures. Not unimportantly, loyalty leads to referrals. With no other input, don't we all listen to our friend's recommendations of health care providers?

If your friend Bob reported eagerly, *"Hey, if you want really great care, go to _____ Medical Facility. They're the best!"* wouldn't this impress and influence you to consider this particular facility?

A well-known medical malpractice lawyer named Alice Barkin once said, *"People don't sue doctors they like."* Countless outcome-based research supports the notion that poor communication creates disastrous sentinel events. Some notable examples:

**JACHO** *(Joint Commission on Accreditation of Healthcare Organizations)* reports that 60% of sentinel events are attributed to poor communication.

A Journal of American Medical Association survey showed that physicians with the lowest patient satisfaction ratings had twice as many risk management episodes as those with the highest satisfaction ratings.

Almost one-third of litigious complaints related in some way to a breakdown in compassionate communication. Terms such as *rude*, *inattentive* and *discourteous* are typically used in such circumstances. How hard is it to avoid being rude or discourteous?

One more indicator: In a Harvard study, deposition transcripts demonstrated four types of communication problems in over 70% of the cases. These included patients feeling deserted,

their concerns devalued, poorly given instructions and failure to see the patient's perspective.

From the evidence above, our task is clear. Nothing short of a committed effort to maximize loving kindness through compassionate communication is required. We owe it to our patients; they deserve nothing less.

### *Recommendations:*

Let's make two new rules of patient contact:

1. Get really good at communication, and
2. Always try to be a little kinder than necessary.

CHAPTER 4

# Update on the HCAHPS, Patient Experience and Healthcare Reform

In an attempt to provide data on Healthcare reform for patients and for government entities, CMS *(Center for Medicare/Medicaid Services)* has developed a formal system to compare patient care in Hospitals and Nursing Homes across the United States. The Hospital Compare website (https//www.medicare.gov/hospitalcompare) features a quality rating using a five-star system.

The star system comparatively rates hospitals on 57 measures of quality care. The hospital may earn between 1 star (poor)

and 5 stars (excellent), compared to all the other hospitals in the country. The seven areas identified by CMS for their value based evaluations include:

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Effectiveness of Care
6. Timeliness of Care
7. Efficient Use of Medical Imaging

The ratings range from "Much Above Average" to "Much Below Average." The goal is to create metrics to objectively measure and compare different health care institutions (and practitioners) on these parameters.

This is therefore a "competition" between healthcare organizations. The belief is that you are being compared to your peers (similar organizations) and scored relative to your peer group. This assumption is probably flawed, but this is the reality. We can complain and "call foul," but the quicker we accept the situation, the quicker we can adapt to this environment and successfully compete. Remember – everyone is going to be addressing these issues/challenges and probably improve, which means to stay at the top quartile or decile will require continued attention to these areas and continuous improvement (CQI)TQM/LEAN Management).

Since the other areas are covered elsewhere, let us amplify the three areas of Mortality, Safety of Care, and Readmission:

**Mortality**

It is important to note that mortality statistics are evaluated in terms of observed to expected rates. The expected mortality rate is determined by how a patient is medically coded on admission. If a patient is critically ill or miscoded (i.e. a terminal cancer is inadvertently not admitted to an inpatient hospice center) and dies in the hospital (or shortly after discharge), this will adversely affect the institution's mortality statistics (this requires specific education of physicians and coding staff).

**Safety of Care**

There has been a lot of work done on creating High Reliability Organizations and Cultures of Safety. A multifaceted approach is needed to design policies, protocols and processes to create a safety structure and foster a safety culture/environment. This includes non-punitive reporting, objective metrics and disciplinary actions when necessary.

**Readmission**

This is really about optimization of care. Healthcare institutions are penalized if a patient remains in the hospital too long (based on admission diagnosis) or if they are readmitted for the same problem within 30 days of discharge. The importance of appropriate coding and post-discharge follow-up (making sure that the patient is being compliant with their medical instructions) needs to be appreciated.

The Value-Based Purchasing system began in 2012 to financially reward hospitals for their quality of care. If the quality of care is "Much Above Average" as rated by the five-star system, the Medicare reimbursement may lead to a 2% increase in funding. This represents a 1.8 billion dollar fund. If the hospital does poorly, the reimbursement is reduced. This provides an incentive for hospitals to be aware of and constantly measure their quality of service.

***Recommendations:***

Become a master of:

1. Your ED CAHPS survey (or equivalent) process that measures your patient care.
2. Your personal scores for:
   - ED
   - Inpatient
   - Clinic
3. The facts about how websites and social media are reporting your outcomes.

CHAPTER 5

# Perceptions and the Power of Presence

Managing patient perceptions is a crucial best practice.

We've been discussing how patients perceive their medical care from their doctors. It's instructive to look at the notion of "perceptions."

In the vast majority of cases, patients are unable to judge the competence of a doctor. They can perceive thoroughness, compassion, sensitivity and listening ability. As we've heard before, perception is their reality, but perceptions can be deceiving (theirs and ours). They may perceive that the nurses and doctors are unkind when they are simply busy and don't have time to chat. Maybe patients think that a healthcare provider is nosy when they ask a lot of personal questions. Maybe they perceive a doctor is uncaring when

they only spend a few minutes with them during morning rounds. Their perceptions are clouded by misinterpretations.

So much of perceptions are based on communication. Physicians often provide advice and recommendations and assume that their patients understand these directions. Making that assumption often results in misconceptions and can negatively influence compliance and the physician – patient relationship.

***"Medicine is about caring and competence and if the patient perceives that you care, competence is presumed."***
***– Dr. Kline***

On the other hand, what is the doctor's perception of how the patients see them? How do they perceive the care we offer? Are we not prone to perceiving that we are doing the best job we can under the circumstances? The patients may see things differently.

Noted Otolaryngologist Doctor C., in an unguarded moment, complained that "My patients don't appreciate the care I give to them and want to tell me all of their problems which are often totally unrelated to their ENT difficulties."

***"No one can tell if you're a good physician or not – but they can tell if you're kind."***
***– Harlen M. Krumholtz MD ,***
***Yale School of Medicine***

**Two Telling Stories:**

An audio survey of 124 physicians in the course of 1000 visits found that patients participated in medical decisions that affected them in only 9% of the visits.

A meta-analysis of doctor-patient communication found that 50% of patients leave an office not understanding what they were told by their physician. This is a tragedy leading to non-compliance and patient dissatisfaction.

A PA revealed an all-too-typical example: a young mother brought her baby in to the doctor because of a persistent cough. After a cursory exam, the doctor wrote a prescription for a nasal spray. When the mother went to the pharmacy, not understanding the connection between her child's nasal infection and coughing, she did not get the prescription filled as ordered but instead bought an over-the-counter cough medicine. A two minute explanation would have led to the mother understanding the problem and complying.

**"You can't read the label if you're inside the bottle."** Yes, perception can equal deception.


*"What I believe doesn't count as much as what my patient perceives."*
*– Brian Lee, CSP*

Why don't we see ourselves the way others see us?

It's because we have a different perspective. We are familiar with our routine and systems. We may do something many times during the day. The patient sees us doing it once. Patients are keenly aware of their doctor's every move, facial expression, and tone of voice. They are concerned, often fearful and on edge. They find themselves in an unusual and somewhat scary environment. We are not in their situation and it's difficult to see their perspective. One way many doctors learn this, is when they become patients themselves.

Here's an important question: why don't patients tell us how they honestly feel about us while they are under our care and control? You can guess the answer; it's hard to give feedback to a learned professional or expert who is serving you, is it not? It's always tough to question authority (especially medical authority) so many patients don't feel they have the right to question or complain.

A senior citizen had his knee surgically replaced. Immediately after the surgery, his leg was placed in a device that moved his leg slowly up and down to promote the proper healing and to maintain mobility. The patient realized that the machine was raising his knee, but didn't lower back down to a level position. He didn't know how to explain this to the doctor. When he tried, the doctor looked at a readout on the equipment and said that the machine was working properly. The patient let it go. He didn't feel justified in questioning the doctor further but later expressed his concerns to his nurse. She brought in her supervisor to check on the motion device and when she examined the apparatus, discovered a problem with the footplate which prevented the leg from being lowered to a flat position, although the readout indicated it was working properly. She adapted the device so it worked correctly. Even for this well-educated and relatively assertive patient, it was hard to question the doctor. The point of this story is that patients have a hard time giving negative feedback or questioning their healthcare givers. We have to constantly check their perceptions.

An important question to consider: what would be the value of objectively measuring patient's perceptions and using that data for continuous improvement? In other words – what

would be the value of getting meaningful feedback? We call feedback the breakfast of champions. It shows what needs to be done to improve things.


As mentioned above, CMS has considered this area of feedback carefully and has instituted a mandatory 32 question survey called HCHAPS (Hospital Consumer Assessment of Healthcare Providers and Systems). Every medical facility is required to send out 75 surveys per quarter. These feedback scores are analyzed, and hospital compensation is linked to the results. This is a growing trend that will soon encompass clinics, ERs, ambulatory surgery and outpatient services. Eventually every form of healthcare provider that is publicly funded is going to be surveyed in this way.

Consider these developments as a great opportunity to develop great clinical care.

Unfortunately, some physicians believe that only negative patients respond to satisfaction surveys, or that there are never enough responses for a statistically valid sample. “You can’t derive any meaningful conclusions from 300 surveys a year.” Said Dr. M, an Internist.

Other physician beliefs about patient satisfaction and productivity:

- "I can achieve strong productivity or strong patient satisfaction, but not both."
- "If I had more time with patients, I'd have great patient satisfaction."
- "Physicians with great patient satisfaction scores are that way naturally. Some have it, but I don't."
- "Patients have unrealistic expectations."
- "My patients are different. Sicker. Non-compliant. Have co-morbidities."
- "The patient satisfaction survey is flawed."
  Permanente Journal, Fall, 2012. Boffelli, Thongvanh, Evans & Ahrens. Patient Experience & Physician Productivity: Debunking the Mythical Divide.

**A realistic conclusion:**

To be successful today, a provider must be skillful in two areas:

- Skillful CLINICIAN
- Skillful COMMUNICATOR

***Recommendation:***

***"The good physician treats the disease; the great physician treats the patient who has the disease."***
***– William Osler. MD 1849-1919***

CHAPTER 6

# Insights from the Voice of the Patient

Most patient survey vendors include actual verbatim patient comments along with their monthly, quarterly and or online reporting of patient perceptions.

Paper survey vendors provide patient comments in a printed format, and phone vendors can transmit the actual voice recording

**Examples of positive patient comments;**

- Staff was pleasant and interested – easy to engage.
- I felt safe and secure during my stay knowing that I was taken care of.
- The staff made a very frightening and stressful situation as pleasant as possible. I will always be grateful.

**Example of negative patient comments;**

- Why would you not take an x-ray at least?! And I'm still hurting, every day. The nurse was distant and not friendly. I'd speak, she wouldn't even look my way. I felt very invalidated and in the way.
- Colonoscopy finished about 1 p.m. discharged about 6:30 pm. Never saw the doctor… sort of a weak debrief on what to do or what had happened during procedure.
- I had terrible pain and no one had any sense of urgency to try and make me feel better.

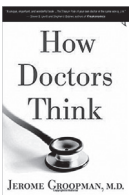
***Recommendations:***

1. Ask Administration to share verbatim comments from your ED CAHPS patient experience survey as a useful tool for continuous professional improvement.
2. Invite everyone to take turns at weekly meetings to read printed comments out loud in the tone of voice intended by the patient. This has a profound impact on listeners and provides a meaningful "reality check" about the impact of their actions. In the case of voice recordings the messages speak for themselves

CHAPTER 7

# What Patients Really Want

How to become skillful at improving your patient's experience?




In Jerome Groopman's book "How Doctors Think", we learn that the average time it takes a doctor to interrupt a patient's initial description of their problem is 18 seconds. Then they start asking their own questions. How is this perceived by the patient? How does this relate to first impressions? How does this make the patient feel about their importance?

Condensing the information presented above, we can see what patients want or expect from their health care providers at the bedside or the examination room.

The three critical areas are:

1. Manners
2. Listening
3. Teaching

*"You never get a second chance to make a positive first impression"*

*– Anonymous*

***Recommendation:***

Take a closer look at the skills needed to be a skillful communicator.

CHAPTER 8

# Skillful Manners

Let's take each of these areas in turn.  What do we mean by "manners" - or what is commonly known as "the bedside manner."

We begin the caring bedside manner by:

- Establishing eye-contact upon entering the room.
- Being alert and focused on the patient and not have our nose buried in the chart.
- Being courteous
- Smiling
- Shaking hands
- A friendly self-introduction: "Hello, my name is _____.

Earlier we suggested that you ask the patient how they would like to be addressed. Indicate this on the white board and remember to address the person thereafter by name. “Good morning Mrs. Johnson.”

Make amends if you are late or the patient has been waiting too long. “Thank you for your patience.”

Other Considerations:

To demonstrate good manners: (common sense stuff):

- Read their chart before entering.
- Knock before entering (KB4E).
- As you settle in, make sure your posture and facial expression are friendly.
- Face the patient and minimize looking at your laptop screen of their chart.
- Sit down in a chair next to the patient.
- In addition we recommend making some physical contact with the patient (i.e. a hand on the arm or shoulder)
- Thank them for being your patient.

Try to “join up” – make a personal comment to establish rapport. A classic way to “join up” is to use the A.F.F.O.R.D. principle. We can quickly and easily connect with a patient in one or more of these areas:

**A - Avocation.** If the patient has an avocation similar to yours or one you know about, mention it to establish rapport. You must be absolutely honest when you do this.

**F - Family.** If their family situation is similar to yours, bring it up. "Oh, I have two sons as well. I know about taking them to sports activities."

**F - From Where.** Everyone is from somewhere! If you have this in common or you know about where they're from, you have something in common.

**O - Occupation**. If their job is similar to one you've had in the past or one of your family members has, you have a basis for discussion. "My sister loves to do ceramics, too."

**R - Recreation.** Do they like to have fun the way you do. Sports or other activities in common? "Like you, I enjoy getting away, out in nature."

**D - Dreams or Desires.** Have they always wanted to get a sailboat of go on an archeological dig? If you've had the same goal, you can connect.

*"Good manners are a way of showing patients that we have respect for them."*

*– Bill Kelly*

Do not spend a significant amount of time typing into your computer while with the patient. If you need to do some typing into their record, explain your actions – for example, "What you are telling me is very important, and I want to make sure that everything is recorded correctly on your medical record. Please excuse me for typing as we speak."

Create a place on the patient's medical record (customized/ individual rolodex) where you can put their personal information, such as their nickname, how they like to be addressed, occupation, hobbies, family members, personal interests… mentioning these items during patient visits strengthens the patient-physician relationship, demonstrates interest, and enhances communication.

***Recommendation:***

*"It doesn't take an instant more, or cost a penny more, to be empathetic than it does to be indifferent."*

*– Brian Lee, CSP*

CHAPTER 9

# Skillful Listening

The second critical area is “skillful listening.”

Use the L.I.S.T.E.N.E.R. acronym to help remember key points of good listening.

**L - Look.** We keep good eye contact with the patient to show: 1) we are listening, and 2) to pick up non-verbal signals from their facial expressions or gestures.

**I - Ignore, reduce or eliminate distractions.** When possible, control the environment to be free of auditory or visual distractions. Sometimes it is as easy as shutting a door, turning off the TV or moving to a quieter location. When this is not possible, do your best to ignore the distractions by selectively focusing on the patient.

**S - Summarize/paraphrase the patient to ensure that you understood them.** This lets them know you've listened. It also reduces their anger or anxiety and reduces or eliminates misunderstandings. This is a powerful communication tool often called, "active listening" or "reflective listening." "What I hear you saying is…" "So, as I understand it, your main concern is…"

**T - Take notes.** Often the patient has complex symptoms or concerns. Taking occasional notes helps to keep track and refer back to key things the patient has said. It also helps with ongoing record-keeping. If not overdone, it won't interfere with the interview.

**E - Emotional self-control.** This can be a challenge for many of us. In various ways, patients can try our patience, become angry or belligerent. Our negative emotional responses can get in the way of listening and reduce our effectiveness. This is especially important when facing an angry patient. (this will be discussed later).

**N - Non-verbal signals.** Non-verbal communication or body language is an INEXACT science. We must be careful not to over interpret these signals. Nevertheless, vocal tones, facial expressions and gestures can contradict what the patient says or augment their communication. When in doubt, check out your observations. "I see a look of doubt on your face," or "You sound skeptical, is that right?" (More on this issue later.)

**E - Economize on interruptions.** Yes, there are reasons to interrupt the patient; such as needing clarification, bringing them back to the topic after they go off on a

tangent, or to correct their misconceptions. Remember to keep these interruptions to a minimum. Let the patient tell their story their way.

**R - Respond.** It is our obligation in a conversation to respond to the speaker. We may do this by asking questions, paraphrasing, explaining or non-verbally by head nodding and by saying "Uh-huh," or "Go on," or "I see."

It is also incumbent on us to listen to what isn't said. What do the symptoms mean to the patient? What might they be asking themselves about their future or what this illness might mean in their lives? We want to remind the patient that we are here to listen to them and that there's no such thing as foolish questions.

***Recommendation:***

*"Listen unto your patients, as you would have them listen unto you."*

*– Anonymous*

CHAPTER 10

# Skillful Teaching

The third area is “skillful teaching.”

We need to educate the person about their illness, its ramifications and treatment plans. They have the absolute right to clearly understand their situation so they can be empowered to make decisions. This is especially significant when dealing with numbers, percentages, treatment risks or medical terminology. For example, a woman fainted when the doctor told her that the lump in her breast was “benign.” We can’t expect people who have had no medical training or experience to understand our jargon. We have to speak to them, their way. Check out their understanding and don’t assume they understood you the first time . Realize the patient may also be under emotional strain, and may not be at their listening best.

The Three Minute Factor:

> ***"Surgeons who've never been sued, spent 3+ minutes longer with each patient that did those who have been sued."***
>
> ***– Malcolm Gladwell, Blink, Little Brown & Co. 2005***

The patient may be asking themselves:

- "Do I understand what is going to happen to me?"
- "Does this make sense to me?"

We can ask questions that help the patient to understand:

- "Many times patients worry about … do you feel that way?"
- "Sometimes patients are understandably confused about… do you have any concerns that I can help you with?"

Whenever possible, use visual props, pictures, models, graphs, etc. to help patients to understand and retain what is said to them. In other words, enhance your message to increase their perceptions and show your own ability to adapt your instructions to suit the patient. This also demonstrates your competence and expertise, and helps to ensure compliance.

In conclusion, work to develop:

- Good manners
- Good listening skills

- Good teaching/explaining

### *Recommendations:*

Make sure that you understand the patient and that they understand you. The tools you have are:

1. The art of inquiry. Questions stimulates thinking and leads to understanding.
2. Paraphrasing. Verify the communication coming and going.
3. To ensure you understand a patient, reflect back or paraphrase and ask, “Do I have that right?”

CHAPTER 11

# Empathy H.E.A.L.s

**3 Provider Skills and Behaviors**

Empathy is the #1 Provider skill.

> ***"Empathy means temporarily living in the other's life, moving about in it, delicately, without making judgments."***
>
> ***– Carl Rogers, Ph.D. American Psychologist***

In the movie, "What women want, Mel Gibson begins to "hear" what women are thinking through quirk of fate. It is humorous to see how he is shocked to hear thoughts about him. He develops a severe case of empathy. In another scene he puts on women's clothes and makeup to "feel" what women feel in order to help him develop an advertising campaign. One wonders how physicians would react to hearing what

their patient's thought of them. We don't have to go to such lengths to be empathetic but it is important to do our best to see our patient's point of view.

Empathy requires some introspection on the part of the caregiver. (Review and understand one's own prejudices, pre-conceptions…and understand that others often have completely different life experiences and perspectives.)

Everyone you meet is fighting a battle you know nothing about. Be kind…always.

Empathy H.E.A.L.s

**H – Hear** the patient and tune in:

- To their individuality. We are all different, unique and have our own quirky personalities. When we really "hear" the individual we enter into "privileged intimacy." This is at the heart of healing.
- Tune in to their emotional and cultural dimensions. Naturally the patient's perceptions are guided by their emotions, their cultural backgrounds and previous experiences. "Hearing" is tuning into those perceptions.

**E – Empathize** through "intentional presence." I want to be authentically here as completely as I can. I intend to focus on this person to get to know their problems and use my best skills to help them. "The deep listening that is part of being empathetic is in fact, the spiritual experience some patients seem to need."

*"Simply listening becomes a powerful and moving experience."*

– *Barry Bub MD*
*Communication Skills That Heal*

**A – Align** with their emotions. Reflect back how you think they are feeling.

- "I can tell you've had a tough time."
- "I can see you're discouraged."
- "I can sense you're disappointed."

This is the essence of compassion-- "feeling with" the patient.

**L – Listen** through silence. (SILENT = LISTEN same letters) Allow silence. Sometimes it helps to give the patient time to digest information. The patient may need some quiet time to formulate a question. And finally, the patient needs some quiet time to get in touch with his feelings and possibly relate them to you. It's OK. Don't panic if the patient goes silent.

Question:

Would you say your patients are getting their daily empathy requirement from you?

***Recommendation:***

Practice this simple “healing” skill

H – Hear

E – Empathize

A – Align

L– Listen

CHAPTER 12

# Conversation Starters

For examples check out the "Patients' Rolodex" to review their personal information. This provides suggestions to initiate a conversation with "small talk."

- "How are those grand kids doing?"
- "Did you see how the dodgers won yesterday?"
- "It's a great day check out the flowers in the hospital garden"
- "I just got off the plane, you know what that's like."

Question: What would be the value of using key words at key times?

Instead of calling it scripting (which might be too specific and lock us into using exact words), let's call it Conversation Starters.

What do these organizations have in common?

- Marriott Hotels
- The Ritz-Carlton
- Hilton Hotels
- American Express
- Chick-Fil-A (and all successful restaurant chains)
- Nordstrom

They all have developed scripting for their employees.

When hotel employees speak to me, I feel welcomed and feel that they will take care of me when I'm on the road and in a strange place.

Jack was on the road doing hospital seminars. "I was beat and came in from the cold, late at night. The hotel clerk greeted me warmly and thanked me for staying at their hotel. He said, 'I'm sure you've had a hard trip let's see what we can do to get you squared away as soon as possible.' Before I left the front desk, he presented me with two warm chocolate chip cookies to take to my room. 'Please call down and let me know if you need anything.' I thanked him and felt very good about my choice to stay at this hotel. His scripting training paid off and it was done very naturally."

So why not use scripting in Health Care? Our patients want to feel welcomed and like our traveler, they certainly want to feel that they are good hands while in a strange place and are vulnerable. The following guidelines have stood the test of time and are helpful for employees to communicate more effectively with their customers. The same can be said of patients.

***Example:*** To help the patient understand the context of care and what to expect.

> "First I'll examine you and then we'll have time for questions." "We need to run _____ tests. This should take approximately _____ minutes." These comments inform the patient about what is about to happen and what will follow. This is empowering and helps the patient feel that he is participating in his own treatment.

***Example:*** When doing active listening, use questions, head nods and "uh-huhs…" We can also say:

> "Tell me more about that."
>
> "And then what happened?"

These leading phrases and responses open up the patient and help the physician to get more salient information.

### *Recommendations:*

1. Make use of one or more of these sentence starters as soon as possible
2. Adapt the wording to fit you and your conversational style
3. The Key to effectiveness is sincerity

***Continued...***

## *Recommendations:*

4. Identify sentence starters you will routinely use to:
   - Set expectations
   - Encourage a positive outlook in patients and family
   - Appreciate patient concerns
   - Motivate patients to change to more healthy and productive behaviors
5. Share your words with fellow team members and invite them to do the same
6. Take pride in creating this personal protocol to enhance your professional practice
7. Read this excellent resource to enhance your skillful Patient Communication:
   "The Language Of Caring Guide For Physicians: Communication Essentials For Patient-Centered Care"
   – by Wendy Leebov EdD and Carla Rotering MD

CHAPTER 13

# Your Voice Is an Instrument

We best connect with patients by giving the right information, at the right time, for the right reason and in a way that they can understand it.

We can also use a gentle touch, when appropriate, which signals healing. There is always a non-verbal component to patient interaction. Let's consider the three most prominent elements.

This is all about "Physician Presence."

Such behaviors as smiling appropriately, having a relaxed demeanor and expression and not always showing the "serious face." There is a time for some lighthearted banter.

Take what you do seriously, but do not take yourself too seriously.

**Voice**

The voice can convey meaning separate from the words. What can you hear in a voice? Surprise, doubt, irritation, excitement? By varying the loudness, pitch and stress, the voice carries emotional overtones. Be sensitive to these and reflect back on them to insure that your interpretation was correct. We must also be aware of our own voice when speaking to the patients. Are we sounding authoritative which may work against our empathizing? Do we sound impatient or inattentive? Remember the patients are judging our vocal quality as we are judging theirs.

**Facial Expressions**

We can also read meaning in facial expressions. Some typical facial expressions are: interest, surprise, anger, joy, sadness, shame, disgust, fear and contempt. How does the patient's facial expression match with what they say? If there is a mismatch, we call that a "mixed message" and we must check out the real meaning. "You said you understand but I see some doubt on your face. Would you like further explanation?" Again, what is our face saying to the patient? Is our face "open" and "welcoming?" Does it show concern?

**Gestures or Body Language**

These movements area usually more direct and easier to read. We all have a naturally rich gesture language. Have you ever tried to communicate with someone in a foreign country when you didn't know their language? How quickly

we resorted to “charades” to get our point across. How is the patient leaning? Are they “closed up” or sitting in an “open” posture? As we lean toward them and match our gestures to what we’re saying, they better understand us.

***Recommendation:***

Be aware.

*“Customers judge you by the way you look, what you say, how you say it, what you do, and how you do it.”*
*– Dale Carnegie*

CHAPTER 14

# Empathize with Difficult Patients and Families

A special communication situation: dealing with the angry patient.

Patients can be difficult for a number of reasons:  Foremost among these are:

1. They feel vulnerable
2. They have an approach-avoidance conflict in seeing doctors and dealing with medical issues.
3. They are often under-informed of misinformed.
4. They often do not hear (or underrstand) important segments of the conversation

5. Frustration
6. Being denied something they think they deserve
7. Being disrespected

We cannot be responsible for someone's anger, but we are responsible for how we respond to a person's anger. They may be yelling, threatening or cursing. Our response will determine if we exacerbate or de-escalate their feelings.

The first step is to remain calm (easier said than done, right?). Physicians need to be the "calm in the eye of the storm." So we make the effort to use positive self-talk, breathe deeply and regularly. Pause before responding using the classic technique of counting to ten before responding. Staying calm will not diffuse the angry patient, but it will not escalate their anger.

Do not order the person to stop yelling or say, "Don't use that tone with me." This sounds like a normal, reasonable thing to say but is not a good thing to do. The angry person hears these statements as challenges or even veiled threats. He feels you are continuing to stifle his feelings or are controlling him. He doesn't feel heard. The angry person needs you to listen and when you order him to do something, he knows you are not listening.

Here is where our discussion of "active listening" will help. Maintain eye-contact and look concerned. Nod appropriately. Do not roll your eyes, frown or mumble your disapproval, but do let the person know, "I get it." Show empathy by saying in one way or another, "I hear you." "I can see you're angry." "I'd be upset too." "That's lousy."

Don't trivialize their concerns by indicating that their problem isn't so bad.

If the patient doesn't settle down, you may have to set limits. "I know you have good reason to be angry, but I need you to stop yelling so I can help you." "It's okay to be angry, but I don't want you to yell at me or call me names."

Here is a short set of guidelines:

1. Listen intently and show it.
2. Show empathy by making empathetic remarks. (Remember not use the word, "exactly" as in "I know exactly how you feel.")
3. Paraphrase to let the person know you were listening; this tends to diffuse their anger.
4. Ask sensitive questions to get details or specifics about their problem. "Tell me more about…?" "Did you mean…?" "What exactly happened?"
5. Work towards a solution. "Let's see what we can do about this right now." Explore options or possibilities. Here is where you get into problem solving.

The interesting thing about these guidelines is that steps 1, 2 and 3 are designed to reduce the negative emotions/ anger.  Steps four and five are designed to activate more rational thought.

***Recommendations:***

- Stay calm
- Listen carefully
- Give yourself permission to pause, maintain self-control and respond with reason.
- Demonstrate empathy and shift into problem-solving

CHAPTER 15

# ED Physician Communication

Perhaps nowhere is the necessity for immediate, clear communication more important than in the emergency room. Instant rapport is crucial.

There is simply no time to correct a wrong first impression. It is important to devote a few extra seconds to make that first impression.

The key elements of a good first impression:

- A relaxed face
- Open body language

- A warm personal self-introduction
- Authentic listening - being sensitive to underlying emotions or fears.
- Demonstrating concern and empathy.
- Reassure the patient that their care and well-being is our primary responsibility.

A Magic Question:

At an ED admitting desk, the intake questionnaire should provide the answer to the question: “What do you hope to get out of this visit?”

***Recommendation:***

If you can’t exactly meet a patient’s expectations, be sure to manage them. Reassure them that you care and will do everything you can to help them.

CHAPTER 16

# Dealing with Drug Seekers in the ER

Chronic pain affects an estimated 116 million American adults. This is more than the total affected by heart disease, cancer and diabetes. Despite their addictive qualities and because they are so effective, opioids have skyrocketed as a drug of choice to control pain. The most common opioids are OxyContin, Percocet and Vicodin; an even stronger drug in this family is Fentanyl, which is synthesized to resemble other opiates such as opium (derived morphine and heroin). Fentanyl is 50-100 times more potent than morphine, and 30-50 times more potent than heroin.

Opioids are extremely addictive. Eighty percent of heroin addicts began by using prescription opioids. Nearly half of all overdose deaths involve prescription opioids; they affect

the part of the brain that regulates breathing and can cause respiratory failure and death.

Consider the numbers: In 2016, over 64,000 Americans died from as a result of an overdose. This is an increase of 21% since 2015. By comparison, in 1999 (only 17 years earlier) the number of overdose deaths was 4,000. In British Columbia, police discovered a lab making 100,000 doses of Fentanyl pills each month. A report from Alberta in 2017 stated that ER visits as a result of opioid overdose rose 1000% in five years.

Center for Disease Control and Prevention Director Thomas Frieden said, “America is awash in opioid, urgent action is critical.” President Trump concurred with the Federal Drug Administration calling opioid addiction a “public health emergency.”

In March 2016, the Center for Disease Control and Prevention published guidelines that recommended opioids as a last resort for pain treatment, to be used in conjunction with other treatments.

***Recommendations:***

Establish protocols that address specific drugs and quantities (no more than a three day supply) that will be dispensed.

***Continued...***

## *Recommendations:*

- Mechanism to get rapid feedback from patient's primary physician.
- Immediate way to check prescription history with local pharmacies.
- Ability to rapidly perform urine and/or blood toxicology/drug screens.
- In private practice, set rules about not filling/ renewing any controlled substance scripts after 4:00 PM Friday through the weekend.
- Try to utilize medications with the lowest abuse potential.

In addition:

- Become familiar with your state's protocols, regulations, and laws.
- Schedule an in-service on the CDC Guideline for Prescribing Opioids for Chronic Pain.
- Apply common sense and good judgment. Ask yourself "How would I treat this patient if they were my mother or my child?"

CHAPTER 17

# Communication Tools

Tools, Equipment and Resources

Here are ten communication tools that highly effective medical providers use in the patient's room.

1. White boards. These can easily provide basic information such as the patient's name, the doctor's name etc. It is also useful to be able to change the information on the board such as the day, date, nurse on duty etc.

2. Wong-Baker "Faces" chart. This has proven to be especially useful for the patients to estimate their pain levels.

3. An anatomy chart to pinpoint area of pain or distress.
4. Models, photographs and diagrams. Sometimes it is easier to "see" what the doctor is saying than to hear it verbally.
5. Chalkboard. This can be handy for diagrams or to sketch out bits of anatomy to help the person to understand.
6. Drawing paper. Similar to the chalkboard. This can be useful for the doctor to make a simple sketch of what they are explaining.
7. A chair. It is best not to hover over the patient unless performing an exam. Being seated puts the doctor on the same level as the patient. A study was done to gauge patient's perception of time when the doctor stood or sat in their room. The results were astonishing. When the doctors stood, the patient estimated the time spent with them was 2-3 minutes. When the doctor sat, the patients estimated the time spent was 10-15 minutes. ALL THE DOCTORS SPENT EXACTLY 5 MINUTES WITH EACH PATIENT. The message when seated is: "I have time for you." The message when the doctors stood is "I'm rushed and don't have time for you."

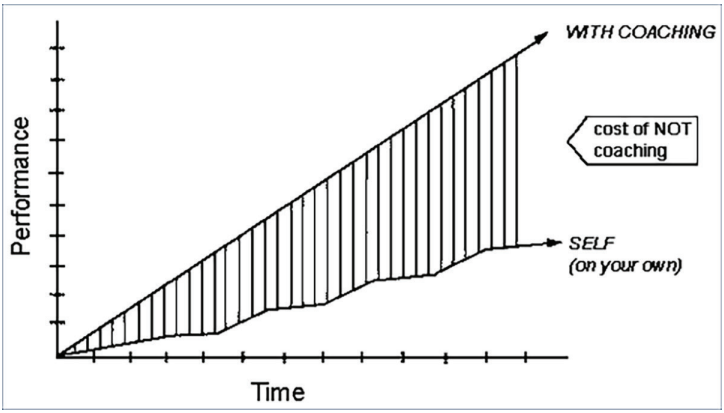
*"When you sit, you're heart to heart."*
*– Brian Lee, CSP*

8. Translators when necessary. Either in person or on the phone. Our patient population is becoming more diverse. Many hospitals have a register of anyone on the staff who can speak another language who can fill in to help with a non-English speaking patient.

9. Smart Apps. i.e. an iPad with easy access to diagrams of the body.

10. A communication coach: If you are struggling with how to apply these communication skills, you might want to enlist the aid of a coach or a partner. The coach's job is to teach, nag, remind and encourage you to continue to communicate at your best. Select a peer or hospital colleague you admire with exceptional communication skills to discuss these issues and how you can improve them.

**The Power of Coaching**



### *Recommendation:*

Review all the tools at your disposal. Check off which of the above tools you will employ to enhance your communication.

- Whiteboard
- Wong-Baker “Faces” Chart
- Anatomy Chart
- Models, Photographs and Diagrams
- Chalkboard
- Drawing Paper
- Chair
- Translator
- Smart Apps
- Communication Coach

CHAPTER 18

# Three Thoughtful Questions that Guarantee Improved HCAHPS Scores

To make sure the patient's experience has been a communication success, wrap up each visit with the following three sets of questions, each relating to the areas of most concern to the patient. Here are some scripting examples of these questions:

**Questions Pertaining to Skillful Listening**

"I want to make sure I've heard and addressed your concerns. They were…"(enumerate the main concerns of the patient).

"Have I got that right?"

"Did I cover everything to your satisfaction?"

"Do you have any questions?"

**Questions Pertaining to Skillful Teaching**

To be certain that the patient internalized and understood what you taught, check it out with the following:

"I want to be confident that you understood our next steps in your plan of care. We'll work together to make sure you get better as soon as possible."

"Could you summarize what you see as our road map to return you to good health?"

**Questions Pertaining to Skillful Manners**

"Thank you for working with me. I realize that _____is of great concern to you. I want you to know that I will do everything I can to deal with those concerns. How are you feeling about our visit today?"

**Note: Validate the Patient**

"You were right to come in with this problem. Your blood pressure was getting up there." "I'm glad you brought your Mom in. We needed to adjust her blood pressure medication."

**Question:**

If you were consistent about wrapping up your patient visits with these patient- focused questions, how positive would the impact be on your HCAHPS scores? How much better

would your patients feel about the care you gave them? Do you think it would impact their compliance?

**Our Challenge:**

*"The practice of Medicine is an art, not a business, but a calling in which your heart will be exercised equally with your head."*

*– William Osler, MD 1849-1919*

***Recommendations:***

1. Adapt these questions to fit your vocabulary and conversational style.
2. Download the "3 Thoughtful Questions" Poster from **www.customlearning.com/3Questions.jpg**
3. Make these questions a vital part of your professional practice – now!

CHAPTER 19

# My Communication DO IT Plan

1. Master the art of compassionate communication
2. Become familiar with HCAHPS surveys Value-based purchasing and the STAR program on an ongoing basis.
3. Use the Art of Inquiry to help patients to understand their condition.
4. Be sure to begin every patient consultation with a self-introduction and small talk (which is really BIG talk).

5. Begin every consultation with “What do you hope you get out of this visit?” Your goal is to wither meet or manage patient expectations.

6. Focus your patient communication on skillful manners, listening, and teaching.

7. Meet with your CNO or Unit Nurse Director to ensure all patient rooms have the necessary tools/resources for patient education.

8. Focus on empathy as a therapeutic psychological nutrient that H.E.A.L.s.

9. Test out the recommended conversation starters; adapt and choose the ones that work best for you.

10. Wrap up every patient visit/consultation with the Three Thoughtful Questions.

11. Form a Patient Experience Improvement Study Group with other physicians to share best practices for improving patient communication.

12. If you are the CMO or Chief of Staff: facilitate a discussion with your colleagues to set an annual goal for the Communication with Physicians domain questions. Ask your colleagues to approve forwarding a quarterly comparative ranking of relevant patient experience scores to every provider on staff.

**A Final Thought:**

***It Is Just Manners***

*It is just manners.*
*There's nothing too complicated about it.*
*It is just saying: how does one human being*
*relate to another human being.*
*We don't need complicated frameworks of communication stuff.*
*We just need a moment of thought, and then,*
*the decency the situation requires.*

– *Arthur Frank, PH.D.*
*University of Calgary*

Our final question to you: how are you going to implement the information you've just read?

**To summarize:**

Skillful ED provider communication heals!

# Addenda

ADDENDUM A

# The HCAHPS Domains

The 11 HCAHPS domains are:

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Control
5. Communication about Medicine
6. Discharge Information
7. Transition of Care
8. Cleanliness of Hospital Environment
9. Quietness of Hospital Environment
10. Overall Hospital Rating
11. Willingness to Recommend Hospital

To get HCAHPS Star ratings, hospitals must have at least 100 complete HCAHPS surveys over the course of a year.

Additional thoughts to ponder:

Physicians are given a tremendous amount of points (as Covey says, “Deposits in the emotional bank account”) by their community and patients just because they have the letters M.D. or D.O. behind their name.

Use this to your advantage as you establish relationships with your patients and their families.

Be non-hierarchical (treat everyone the same). This is so uncommon among physicians that those who are able to do this are seen as stars.

Physicians’ attitudes and behaviors that follow will be key determinants of the culture of a practice and of the health care institutions where they work.

**Set expectations:**

Under-promise and over-deliver.

ADDENDUM B

# Hippocratic Oath: Modern Version

**I swear to fulfill, to the best of my ability and judgment, this covenant:**

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must

be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

– Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.

ADDENDUM C

# Recommended Reading

- ***The 7 Habits of Highly Effective People*** – Stephen R. Covey
- ***The Fifth Discipline (The Art & Practice of the Learning Organization)*** – Peter M. Senge
- ***Managing in a Time of Great Change*** – Peter F. Drucker
- ***The Pursuit of WOW!*** – Tom Peters
- ***Embracing Chaos*** – Tom Peters
- ***Reengineering the Corporation*** – Hammer & Champy
- ***Who Moved My Cheese*** – Spencer Johnson, MD
- ***"The Language Of Caring Guide For Physicians: Communication Essentials For Patient- Centered Care"*** – Wendy Leebov, EdD, and Carla Rotering, MD

ADDENDUM D

# Evidence Based Research in Support of Skillful Physician Communication

Robert Tanner, ***Business Consulting Solutions, October 10, 2017***

> The Beauty of Maslow's Theory is that it takes into account that an employee's needs change with time.

***Journal of Personality and Social Psychology*** v.101, issue 2, p. 354.

> Maslow's theory is widely accepted but not empirically validated. It is seen as a broad concept and provides a useful framework. Current authors accept the 70-year-old initiative as a breakthrough in needs theory. Recently the modifications are based on culture differences and that the "need levels" may overlap. (The original theory indicated that one level had to be satisfied before a person moved to the next highest level.) Saul McLeod updated these findings in 2016.

Tay & Diener, 2011, cited in the same study above, using 60,000 participants, that universal needs exist in all cultures but the order and overlap is significant

In the popular book ***You Can Negotiate Anything***, Herb Cohen, said "It is the 'how' (emotional content of an encounter) that drives the 'what' or the facts of the event."

In 1994, Dr. R. Sagall refers to the frequent mismatch of patient's expectations with the reality of the encounter with physicians.

In March 2011, Dr. Pauline Chen said "Even well-informed patients may be blinded by 'unrealistic optimism.'"

"Why Patients Have Lost Trust in Doctors" Myers Riner, MD (ER Physician) in the ***Daily Beast,*** February 2014. He uses the comparison between Dr. Macus Welby, the caring, thoughtful, competent, ethical practitioner with Dr. House, the brusque, uncaring, addicted doctor. Dr. Rost in the same article mentions that most doctors are businessmen first and doctors second. Also, there has been a lot of negative press in high profile cases of fraud, drug abuse, drug pushing and malfeasance. Finally, "Capitation" creates a climate where some doctors hesitate to order a test or treatment. In contrast, the Gallop poll reports 70% trust in doctors. He concludes that MDs must earn the trust of patients and guard against the intrusion of business.

***Becker's Hospital Review*** September 29, 2015. Emily Rappleye said that patient's expectations are propelled by the force of technology. The digital world is shaping patient's expectations. Dr. Kharray reported three expectations patients have, and how to meet them:

1. Immediacy – Patients are accustomed to getting things NOW. It might better to have them book appointments on line.

2. Choice – The patient doesn't want to be "owned" they want to choose their preferences. If patient's can have after-hours appointments or weekend appointments you can retain these patients.

3. Personalization – Least obvious. "Evidence – based messaging" leads to tailored direct messages that are appreciated.

Michael Marteneau recommends using "Patient" rather than "Consumer." This should help changing the perspective in booking appointments or renewing prescriptions. Booking appointments can be a nightmare for patients. E-booking is often preferred.

Impact of ACA on Doctors: Sander LaMotte, CNN January 17, 2017, in an interview with Urologist Brian Hill, MD.

> ACA goes too far with regulations taking us away from providing health care. It is a burden for the doctor. Negativity affects the doctor's reimbursements. The added non-client duties and paperwork makes us see more patients in less time to keep up with expenses.
>
> It is a mixed bag to be sure. Acceptance of ACA goes along political lines and is more acceptable in safety-net setting serving the indigent and less fortunate. In a survey from Kaiser Hospitals, four out of ten doctors believe the ACA has a negative impact on patient's

out-of-pocket expenses. In another survey to 10,000 doctors fewer than 3% awarded the ACA an "A". Age also played a role, the younger doctors being more accepting of the ACA. But as others point out, for some, it is all they've known.

The ACA seeks to lower costs by reducing ER visits through prevention. That is why it is mandated. The ACA requires computerization of all medical records. There are over 140,000 codes for diagnoses. This has led to a need for more IT, more staff, less reimbursement and generally more expenses.

***International Journal of Nursing Studies,*** February 2013, v. 50, discusses retention 30% of the nurses studied have the intention to leave the acute hospital setting. What helps?

1. Flat organizational structure.
2. Participative management.
3. Educational programs.
4. Career opportunities.

***"Improving the Bottom line in Hospitals",*** International Interior Design Assn. 2010.

33 billion dollars were spent on hospital construction by 2010. Design can decrease staff turnover, attract additional patients and reduce costs. To keep patients happy, we must keep the staff happy. Make for comfortable surroundings. JCAHO reports a staff turnover of 20%. This can be reduced by…

- Larger nurse' stations made for group discussions.

- Reduce stress to reduce the 70% turnover in housekeeping by better interior surfaces easier to clean, and better cleaning processes.
- Patients are more attracted to well-designed hospitals which are pleasing to the eyes and comfortable. When patients are more satisfied with their environment they are more satisfied with their health care.
- Better design also reduces falls (especially between the bed and bathrooms where most falls occur).
- Better lighting control and acoustics make for better sleep and rest.

***"Going Beyond HCAHPS to Improve Patient's Experience."*** Willa Maples, MD., H&HN, an AHA pub. January 2017.

> HCAHPS does not go far enough into the complexity of the patient experience. Metrics should be broadened to include assessment of teamwork, communication and the connection between patients and caregivers. High levels of teamwork, relationship-based patient centered communication yields a 5-1 return on investment (ROI). Use different and more varied data to get a more complete picture of patient satisfaction.

***"No Complaints: How to Improve the Patient Experience."*** McKessen, Changehealthcare.com July 11, 2016.

Keith Slater, VP Patient Access. In 2016, in a survey of 35,000 on line reviews of MDs showed that Customer Service is the

primary frustration of patients. 96% of patient complaints were related to customer service issues.

- Patients these days have higher expectations. Upper management is often unaware of the communication problems between the patients and their doctors. First and last impressions, slower response times, not knowing how to apologize and a lack of purpose (mission) vs. job function. One solution – better equipped and well-trained staff in call centers.
- Rounding – several hand-held devices are advertised in medical articles which greatly help rounding.
- Clarifare, Vocera EMMI, devices.
- C.A.R.E. Channel, 2017. Nature videos and music to relax patients and help them sleep.

*"Five evidence Based Ways to Increase Patient Satisfaction."*
David Craig, MD posted on BLOG August 2016

1. Get creative with the WAIT. It really helps if the waiting area is comfortable and pleasant.
2. Spend time with patients.
3. Sit down.
4. Dress like a boss.
5. Good communication reduces lawsuits.

Research to support the above:

***"Effects of Actual Waiting Time."*** Thompson D.A. et al. Ann. Emerg. Med. 28, 657-665 1996

***"The Psychology of Wait times."*** Maister D.H. www.david-maister .com 1985

***"Is Patients perception of Time Spent with a physician a detriment to Ambulatory Patient's Satisfaction."*** Lin C.T. Et al. Arch. Inter. Med. 161 1437-1442 2001.

***"To Sit or Not to Sit."*** Johnson R. L. et al. Ann. Emerg. Med. 51 188-193 2008

***"Sitting at the Patient's Bedside may Improve Patient's Perception of Physician communication skills."*** Merel S.E. et al. , J. Hosp. MED., 2016.

***"Effect of Sitting vs. Standing on perception of Provider time at Bedside: a pilot study."*** Swaden K. J. et al. Patient Educ. Couns. 86, 166-171 2012

***"The Relation of Patient Satisfaction with Complaints against Physicians and Malpractice Lawsuits."*** Stelfox H.T. et al. Am J. Med. 18 1126-1133 2009.

***"Association of Perceived Physician communication Style with Patient Satisfaction, Distress, Cancer Related self-sufficiency and Perceived Control over the Disease."*** Zachariae R. et al. Brit J. Cancer 88, 658 665 2016

In 2010, The Ochsner Journal did a major review of doctor patient communication with 47 references.

*Doctor-Patient Communication: A Review*

Part of the abstract indicates that doctor-patient communication is central to the doctor-patient relationship and that doctors tend to overestimate their communication abilities.

***"Communication of affect between patient and physician"*** Hall J. A et al. J. Health Soc. Behavior, 1981: 22 (1) 18-30

***"Assessing competence in communication and interpersonal skills: the Kalamazoo II Report"*** Duffy F.D. et al. Acad. Med. 2004: 79 (6) 495-507

***"Assessing the communication and interpersonal skills of graduates of international schools as part of the U&S. Medical licensing Exam"*** Van Zantan et al. (USMLE) step 2 clinical skills (CS) Exam. Acad. Med. 2007: 82 (10 Suppl) S65-S68

***"Doctor-patient communication and satisfaction with care in Oncology."*** Bredart A. and Bouleuc C. Curr Opin Oncol. 2005: 17 (14) 351-354

From the four references above the following factors emerge.

- Doctor's communication and interpersonal skills are the core skills of Medicine with the ultimate goal in achieving patient satisfaction.
- Patient surveys consistently show patients want better communication with doctors.
- Effective doctor-patient communication or "bedside manner" are the ways the patients judge a doctor's competence.

- Satisfied patients are less likely to sue for malpractice.

***"A Six-step Protocol for Delivering Bad News: An Application to the Patient with Cancer"*** Baile et al., 2000: 5 (4) 302-311 Reported that patients often report their doctors as one of their most important sources of psychological support. Especially when the doctors can show empathy. Baile also indicated that miscommunication decreases patient's satisfaction, level of hopefulness and subsequent psycho. adjustment.

***"Communication Skills for Patient-centered Care: Research-based Easily Learned Techniques for Medical Interviews that Benefit Orthopedic Surgeons and their Patients."*** Tongue et al., J. Bone Joint Surg. Am. 2005 87:652-658 they report that 75% of the ortho. surgeons believed that they communicated satisfactorily to their patients. But only 21% of their patients reported being satisfied with their doctor's communication. Also that most complaints about doctors are related to issues of communication not clinical competency.

***"Interacting with cancer patients: the significance of physician's communication behavior."*** Arora N. Soc. Sci. Med. 2003: 57 (5) 791-806

***"The contributing role of healthcare communication to health disparities for minority patients with asthma."*** Diette G. B., Rand C. , Chest 2007: 132 (5 suppl) 802S-809S

The two studies above both indicate that doctor-patient communication increases patient involvement and adherence to recommendations and patient satisfaction.

***"Effect of Multi-Source Feedback on Resident Communication Skills and Professionalism"*** Brinkman W. B. et al., a randomized controlled trial. Arc. Pdeiatr. Med. Adloesc. 2007 : 161 (1) 44-49

***"Chinese HIV-Positive Patients and their Healthcare Givers: Contrasting Confucian Versus Western Notions of Secrecy and Support."*** Chen et al., ANS ADV Nurse Sci. 2007 304 (4) 329 342

***"Effect of Clinician Communication Skills Training on Patient Satisfaction: A Randomized Controlled Trial."*** Brown et al., Ann Intern Med 1999 131 (11) 822-829. The three studies above indicate that satisfied patients are less likely to sue.

***"Differences in physician and patient perceptions of uncomplicated UTI symptom severity: understanding the communication gap."*** Platt F. W. and Keating K. N., Int. J. Clin. Prac. 2007 61(2) 303-315 (Along with the studies by Arora and Bredart above) Pratt found that patients who report good communication with their physicians are more likely to be satisfied with their care, follow advise and adhere to prescribed treatments.

***"Continuing concerns, new challenges and next steps in physician-patient communication."*** Henrdon J. And Pollick K , J. Bone Joint Surg. Am 2002:84-A (2) 309-315

***"The impact of patient–centered care on outcomes"*** Stewart et al., J. Fam Pract. 2300 49: (9) 796-804 Doctors tend to overestimate the effectiveness of their communication abilities.

***"Physician/Patient communication: Transmission of information and patient effects."*** Roter D., L., Md State Med. J. 1983: 32 (4) 260 -265

***"Physician gender effects in medical communication: a meta-analytic review."*** Roter D., L. et al., JAMA 2002: 288 (6) 756-764

***"Key communication skills and how to acquire them."*** Maguire P. Pitceathly C., BMJ 2002: 325 (7366) 697-700. These five studies show a decrease in the length of hospital stay when physician-patient communication is effective.

***"ALS patients and caregivers communication preferences and information seeking behavior."*** Chio A. et al., Euro J. Neuro. 2008: 15 (1) 55-60. This study reports that attentive listening skills, empathy, and use of open-ended questions are examples of skillful communication. And that this skillful communication increases patient involvement, adherence to recommended therapy, patient satisfaction and healthcare utilization and health outcomes.

***"Collaboration communication in pediatric palliative care; a foundation for problem-solving and decision-making"*** Feudtner C., Pediatr Clin North Am 2007:61 (8) 1390-1395 Doctors must take time or set up opportunities to offer and discuss treatment choices to patients and share responsibility and control with them.

Conclusion from the Ochsner Review:

Doctors with better communication and interpersonal skills are able to detect problems earlier, can prevent medical crises, and expensive intervention and provide better support to their patients. This in turn leads to higher quality outcomes and better patient satisfaction, lower costs of care, greater

patient understanding of health issues and better adherence to treatment processes.

***"Breaking Bad News"*** Vandekieft G. K., Am. Fam Physician 2001: 64 (12) 1975-1978 This researcher listed three communication techniques when breaking bad news.

1. Prepare your comm. in advance
2. Validate emotions
3. Deal with family members

Accreditation council for Graduate Medical Education recommend key communication skills for doctors to develop: ***"Toolbox for the evaluation of competencies"*** www.ccgme.org

1. Listening
2. Eliciting information by asking effective questions
3. Providing clear information at the patient's level of understanding
4. Counseling and educating patients
5. Making informed decisions based on patient information and preferences.

***"Practical steps in developing effective communication with patients."*** Travaline J. et al., J. Osteopathic Assn. Jan. 2005 v.105 13-18

1. Assess what the patient already knows
2. Assess what the patient wants to know

3. Be empathetic
4. Slow down
5. Keep it simple
6. Tell the truth
7. Be hopeful
8. Watch the patient's body and face – respond to those cues and be aware of your own non-verbal behavior
9. Be prepared for a reaction

Jeffrey D. MD from the Center of Population Health science in Edinburgh Scotland reported in the Huffington Post in 2016 that Medical students show a decline in empathy as they get further into their training. Doctors can better serve their patients by striving to have empathy rather than sympathy or compassion. Empathy means imagining what it is like to be a specific person undergoing a specific experience rather that imagining that they themselves are undergoing the experience.

Also reported in the Huffington Post 2012. Dr Remer created a course at U. of Cal SF for medical students to focus on communication with patients. One of the factor stressed was listening with more openness.

In 2015, at the National Health Policy Conference in Washington, DC, Dr. Stephen Berkshire a member of the American College of Healthcare Executives stressed that the main topic of the Conference was doctor-patient communication. He

reports that a long-standing complaint of patients was that doctors don't listen to me and don't provide information I can understand. As an example, he cites Dr. Oz'z popularity because of his ability to make health care topics easy to understand. He is accessible, empathetic and takes the mystery out of frightening health issues. The takeaway from the conference was that doctor-patient communication is the #1 challenge in today's healthcare environment. Patients want to have a relationship with their doctors. We want them to communicate, educate us and meet us at our level. Dr. Berkshire has taught physician-patient communication and empathy skills with extreme success.

Dr. Wolff, MD a family physician from Greensboro NC reports that because HMO's and hospitals are demanding that doctors see more patients in a day, so they are spending less time with each patient. The first thing to suffer is good communication. The doctors need to communicate "smarter." Here are some practical tips.

- Don't omit the pleasantries. This is relationship building at its most basic.
  - Smile.
  - Shake hands.
  - Use the patient's name.
  - Sit down to get at eye level.
  - Maintain eye contact.
- These pleasantries relax the patient and help them up to communicate more openly.
- Don't appear rushed by looking at your watch or keeping your hand on the door handle.

- Keep the communication on track.
- Communicate with a dual purpose: to get information and demonstrate interest in the patient.
- Listen without interrupting.

***"Verbal response mode profiles of patient and physicians in medical screening interviews."*** Stiles W. B. et al., J. Med. Educ 1979 54 81-90

Organize your interview:

- Ask open-ended questions to seek clarification
- Use reflective listening (paraphrasing)
- If a psychological component is suspected use the BATHE technique:
  - **B** Background "Tell me what's happening?
  - **A** Affect How do you feel about it?
  - **T** Trouble what's upsetting about it?
  - **H** Handling How are you handling it?
  - **E** Empathy That must be difficult for you.
- Make an attempt to build trust by listening, focusing on the patient, giving them options to empower them, and let them know they can ask questions.
- Provide more information in less time. Summarize yourself and consider giving out pamphlets about their disorder.
- Go the extra mile.
- Follow up with test results.

# Skillful Physician Communication

Master the Communication Skills of a Compassionate Patient-Experience

- Understand why patients place more importance on interpersonal skills than on medical judgment or experience
- Communicate skillfully with patients at their level
- Make the most of your time with patients
- Leverage practical tools to empower the patient and improve outcomes
- Apply thoughtful questions that guarantee improved HCAHPS scores

*"As you journey through the pages of this book… you will find increasing satisfaction and joy in your practice of medicine."*

– Michael A Klein, MD, CMO

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