

**Annotated Bibliography**  
**Treating Patients with C.A.R.E.**



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# Treating Patients with C.A.RE. Literature

† Adams A, Realpe A, Vail L, Buckingham CD, Erby LH, Roter D. (2015). **How doctors' communication style and race concordance influence African-Caribbean patients when disclosing depression.** *Patient Educ Couns*, 98(10):1266-73. doi: 10.1016/j.pec.2015.08.019.

**OBJECTIVE:** To determine the impact of doctors' communication style and doctor-patient race concordance on UK African-Caribbeans' comfort in disclosing depression.

**METHODS:** 160 African-Caribbean and 160 white British subjects, stratified by gender and history of depression, participated in simulated depression consultations with video-recorded doctors. Doctors were stratified by black or white race, gender and a high (HPC) or low patient-centred (LPC) communication style, giving a full 2×2×2 factorial design. Afterwards, participants rated aspects of doctors' communication style, their comfort in disclosing depression and treatment preferences

**RESULTS:** Race concordance had no impact on African-Caribbeans' comfort in disclosing depression. However a HPC versus LPC communication style made them significantly more positive about their interactions with doctors ( $p=0.000$ ), their overall comfort ( $p=0.003$ ), their comfort in disclosing their emotional state ( $p=0.001$ ), and about considering talking therapy ( $p=0.01$ ); but less positive about considering antidepressant medication ( $p=0.01$ ).

**CONCLUSION:** Doctors' communication style was shown to be more important than patient race or race concordance in influencing African Caribbeans' depression consultation experiences. Changing doctors' communication style may help reduce disparities in depression care.

**PRACTICE IMPLICATIONS:** Practitioners should cultivate a HPC style to make African-Caribbeans more comfortable when disclosing depression, so that it is less likely to be missed.

Allen MH, Carpenter D, Sheets JL, Miccio S & Ross R. (2003). **What do consumers say they want and need during a psychiatric emergency?** *Journal of Psychiatric Practice*, 9(1):39-58.

Behavioral emergencies are a common and serious problem for consumers, their families and communities, and the healthcare providers on whom they rely for help. In recent years, serious concerns about the management of behavioral and psychiatric emergencies-in particular, the misapplication and overuse of physical and chemical restraints and seclusion-have become a focus of attention for mental health professionals and policy makers as well as for the lay public, the media, and patient advocacy organizations. Policy leaders and clinicians are searching for ways to balance the rights of consumers with considerations of safety and good care in an area in which it is difficult to conduct research. A survey of mental health professionals who are experts on the treatment of psychiatric and behavioral emergencies identified consumer input and collaboration between patient and clinician whenever possible as being extremely important in achieving the best short-term and particularly the best long-term outcomes for patients. The survey of consumer perspectives described in this article was undertaken in response to the need to better understand consumer experiences and preferences. The authors describe four emergency services forums conducted in 2002, which involved a total of 59 consumers. Each forum involved a written consumer survey as well as a workshop to develop and prioritize recommendations for improving psychiatric emergency care. The authors present the results of the consumer survey and summarize the top recommendations from the workshops. In both the survey and the workshops, the consumers repeatedly stressed the importance of having staff treat them with respect, talk to them, listen to them, and involve them in treatment decisions. There were a number of important areas of agreement between the recommendations of the consumer panel and those of the experts in emergency psychiatry surveyed for the Expert Consensus Guidelines on the Treatment of Behavioral Emergencies. These include the desirability of verbal interventions, the use of a collaborative approach, and the use of oral medications guided by the individual consumer's problems, medication experiences, and preferences. The majority of the consumer panel reported adverse experiences with general hospital emergency rooms and, in fact, called for the development of specialized

psychiatric emergency services such as those recommended in the Expert Consensus Guidelines. One-fifth of the consumer panel attributed their emergency contact to lack of access to more routine mental healthcare. The consumers clearly do not reject medications categorically. Almost half indicated they wanted medications and a similar number indicated benefit from medications, although many complained of forced administration and unwanted side effects. The consumer panel preferred benzodiazepines and ranked haloperidol as a least preferred option. Among their key recommendations for improving psychiatric emergency care, the consumer panel stressed the development of alternatives to traditional emergency room services, the increased use of advance directives, more comfortable physical environments for waiting and treatment, increased use of peer support services, improved training of emergency staff to foster a more humanistic and person-centered approach, increased collaboration between practitioners and patients, and improved discharge planning and post-discharge follow-up. The implications of these findings for improving psychiatric emergency care are considered.

Ambady N, Laplante D, Nguyen T, Rosenthal R, Chaumeton N & Levinson W. (2002). **Surgeons' tone of voice: a clue to malpractice history.** *Surgery*, 132(1):5-9, 2002.

**BACKGROUND:** Interpersonal aspects of care, such as the communication behaviors of physicians, are often cited as central to patients' decisions to initiate malpractice litigation. Relatively little is known, however, about the impact of the communication behaviors of surgeons. In the current study, we investigated the relationship between judgments of surgeons' voice tone and their malpractice claims history.

**METHODS:** We examined the relationship between surgeons' voice tone during routine office visits and their history of malpractice claims. Surgeons were audio-taped while speaking to their patients during office visits, and very brief samples of the conversations were rated by coders blind to surgeons' claims status. Two 10-second clips were extracted for each surgeon from the first and last minute of their interactions with 2 different patients. Several variables were rated that assessed warmth, hostility, dominance, and anxiety from 10-second voice clips with content and 10-second voice clips with just voice tone.

**RESULTS:** Controlling for content, ratings of higher dominance and lower concern/anxiety in their voice tones significantly identified surgeons with previous claims compared with those who had no claims (odds ratio [OR] 2.74, 95% confidence interval [CI] 1.16 to 6.43 for dominance; OR 0.46, 95% CI 0.21 to 1.01 for concern/anxiety).

**CONCLUSIONS:** Surgeons' tone of voice in routine visits is associated with malpractice claims history. This is the first study to show clear associations between communication and malpractice in surgeons. Specific types of affect associated with claims can be judged from brief audio clips, suggesting that this method might be useful in training surgeons.

† Amer A & Fischer H. (2009). **"Don't call me 'mom'": how parents want to be greeted by their pediatrician.** *Clinical Pediatrics* (Phila), 48(7):720-2 (ISSN: 1938-2707).

**BACKGROUND:** Physician-patient interaction during the medical interview is essential in establishing the rapport necessary for a successful relationship. Physicians are generally encouraged to shake hands with patients, address patients by name, and identify themselves.

**OBJECTIVE:** To define parents' expectations for greetings by pediatricians and to determine the frequency with which these expectations are met.

**DESIGN AND METHODS:** A total of 100 parents visiting the General Pediatric Clinic at Children's Hospital of Michigan were recruited. Parents were interviewed at the end of their medical encounter to determine expectations for greeting by their doctor. They were questioned about preferences for shaking hands, the doctors' use of their names, and the way doctors should introduce themselves. They were then asked if the experience at this visit conformed to these expectations.

**RESULTS:** Overall, 81% of the parents were the children's mother and 86% were African-American. Over 80% of parents expected physicians to shake hands; 70% of residents and 66% of attendings did. 88% of parents wanted to be addressed by their names; only 14% of residents and 24% of attending physicians did so. All of the parents wanted the physicians to introduce themselves; 84% of residents and 93% of attendings did so.

CONCLUSIONS: Physicians neither shook hands with many parents who expected it, nor did they address parents by their last names. About 90% of physicians introduced themselves. These disappointingly low results may predispose to parent dissatisfaction. Attending physicians need to teach these small, but important features, and to model them as well.

Andaleeb SS. (1998). **Determinants of customer satisfaction with hospitals: a managerial model.** *International Journal of Health Care Quality Assurance*, 11(6): 181-188.

States that rapid changes in the environment have exerted significant pressures on hospitals to incorporate patient satisfaction in their strategic stance and quest for market share and long-term viability. This study proposes and tests a five-factor model that explains considerable variation in customer satisfaction with hospitals. These factors include communication with patients, competence of the staff, their demeanor, quality of the facilities, and perceived costs; they also represent strategic concepts that managers can address in their bid to remain competitive. A probability sample was selected and a multiple regression model used to test the hypotheses. The results indicate that all five variables were significant in the model and explained 62 per cent of the variation in the dependent variable. Managerial implications of the model are discussed.

OBJECTIVE: To assess whether perceived caregivers' quality of communication, competence and quality of facilities increases levels of patient satisfaction; to assess the relationship between hospital staff demeanor and patient satisfaction; and to assess whether the perception that hospital costs are excessive decreases patient satisfaction.

DESIGN: Exploratory, in-depth interviews followed by questionnaire given to a multi-stage probability sample.

SETTING: Large city and suburb in Pennsylvania, with 4 hospitals

SUBJECTS: n=130

INTERVENTION: none.

DATA COLLECTION: To assess the factors influencing patient satisfaction, respondents completed a mail-survey with questions asking them to rate their agreement on a 5-point scale. Demographic, socio-economic, and patient satisfaction questions were included.

DATA ANALYSIS: Reliability and validity checks were completed. Multiple regression was used to identify the variables influencing patient satisfaction.

FINDINGS: Perceived competence of the staff and their demeanor had the greatest impact on patient satisfaction, followed by perceived expense of hospital services. Staff communication and the general condition of the facilities also significantly affected patient satisfaction, but to a lesser degree.

CONCLUSIONS: Hospital managers can train staff to improve patient satisfaction. In terms of communication, patient satisfaction can be increased when staff explains medical procedures, discuss patient concerns, and consult with patients about their care.

† Anhang Price R, Elliott MN, Zaslavsky AM, Hays RD, Lehrman WG, Rybowski L, Edgman-Levitan S & Cleary PD. (2014). **Examining the role of patient experience surveys in measuring health care quality.** *Med Care Res Rev*, 71(5):522-554.

Patient care experience surveys evaluate the degree to which care is patient-centered. This article reviews the literature on the association between patient experiences and other measures of health care quality. Research indicates that better patient care experiences are associated with higher levels of adherence to recommended prevention and treatment processes, better clinical outcomes, better patient safety within hospitals, and less health care utilization. Patient experience measures that are collected using psychometrically sound instruments, employing recommended sample sizes and adjustment procedures, and implemented according to standard protocols are intrinsically meaningful and are appropriate complements for clinical process and outcome measures in public reporting and pay-for-performance programs.



Bonvicini KA, Perlin MP, Bylund CL, Carroll JG, Rouse R, & Goldstein MG. (2008). **Impact of communication training on physician expression of empathy in patient encounters.** *Patient Education and Counseling*. Available online 10 Dec. 2008.

**OBJECTIVE:** To examine whether an educational intervention that focused on physician communication training influenced physician empathic expression during patient interactions.

**METHODS:** This study used a quantitative research method to investigate influence of communication training on physician-expressed empathy using two measures (global and hierarchical) of physician empathic behavior.

**RESULTS:** The differences in global empathy scores in the physician training group from baseline to follow-up improved by 37%, and hierarchical scores of physician empathic expression improved by up to 51% from baseline scores for the same group.

**CONCLUSIONS:** The results strongly supported the hypotheses that training made a significant difference in physician empathic expression during patient interactions demonstrated by both outside observer measures of global ratings and hierarchical ratings of physician empathic behavior.

**PRACTICE IMPLICATIONS:** These findings have significant implications for program design and development in medical education and professional training with the potential to improve patient outcomes.

† Bothell TW & Harrell G. (2001). **Treating Veterans with Care Impact Report.** Department of Veterans Affairs Employee Education System.

**PROJECT DESCRIPTION:** The Jack Phillips Center for Research and Assessment of the Franklin Covey Company has partnered with the Department of Veterans Affairs Employee Education System over the last two years to complete return on investment evaluations on certain training programs and to educate EES personnel about return on investment. Thus far, VISN 14, VISN 8, VISN 9 and VBA have participated in the ROI studies and education.

Participating VISN's selected 3 training programs to evaluate. In VISN 8, the selections were coding training, leadership training and C.A.R.E. training. The evaluation work that takes typically 5 to 16 full days over time is shared between the Franklin Covey Jack Phillips Center for Research and EES. The Jack Phillips consultants complete around 5 - 7 days of the work and VISN education employees complete the remainder. What follows is a list of the major reasons for implementing these types of projects within VISN's:

1. To demonstrate the value of the learning and performance improvements that occur within VISN's
2. To evaluate the design and delivery of key training programs in order to recommend changes
3. To remove barriers that keep participants from applying skills and knowledge gained in the programs
4. To evaluate the return on the investment and to determine if the programs are cost-effective
5. To provide feedback about the quality of teaching within the program
6. To make recommendations for future training within the VA

The C.A.R.E. training program was selected as a program to be evaluated because the program is highly visible, reaches a large and diverse audience and was intended to be a national effort across VISN's. Additionally, the C.A.R.E. program meets strategic criteria because improving patient satisfaction is critical to the future strategies of the VHA.

**SUMMARY OF THE EVALUATION FINDINGS:** The results reported in this evaluation study describe how C.A.R.E. training makes a positive difference for VISN 8 employees and veteran patients. Similarly, the results show how trainers are well received, how participants of C.A.R.E. learn about VHA customer service standards, and how the participants of C.A.R.E. can apply what they learn to make a difference in patient satisfaction. This study estimates the monetary value of each patient at VISN 8 and suggest the monetary value of improving patient satisfaction

scores. In short, a positive return on investment can be received from C.A.R.E. training. For further information concerning this project, contact any of the major contributors listed on the cover page.

**SUMMARY OF CONCLUSIONS:** The findings of this study are encouraging. The participants' react positively to the program and learn about skills that affect patient satisfaction. However, the reported improvements in participants' skills are not as great as they could be. Participants face many barriers that keep them from applying C.A.R.E. skills. Yet, even with participants' limited applications, participants report that key organizational results are influenced by the program. Those improvements in organizational results produce a positive return on investment. These findings are positive. For the ROI calculation, only 3 organizational results were used in this study. Each result was used to generate a separate ROI calculation. This provided 3 different ways of looking at the ROI of CARE training. The first organizational result used to calculate ROI was time savings. The second was improvements in patient satisfaction scores and the third calculation was computed using participants' estimates of the monetary value of what they did differently because of the program. Each ROI calculation was positive. The value of one satisfied patient within VISN 8 over the lifetime of potential service for VISN 8 patients was considerably high. Improving patient satisfaction scores by a small amount can have a substantial influence on the future of VISN 8.

**SUMMARY OF RECOMMENDATIONS:** There was not a significant difference between C.A.R.E. participants' skills and the control groups' skills. The participants mention many barriers that keep them from applying what they learn. These barriers need attention and should be discussed. Improvements in the design of the course can help to remove many of these barriers and can help participants to better apply and practice what they learn.

Participants report a need for changes to be made within VISN 8. Some of the changes refer to future training and some of the changes refer to systems and processes that need improvements. Frequent among the suggestions were improvements requested in employee morale and employee respect toward each other regardless of level of leadership. Other suggestions included making incentives fair, disciplining non-performing employees and improving interdepartmental collaboration. Finally, a key finding of this study involves the monetary value that can be placed on the retention of a satisfied veteran patient and the monetary value that can be placed on gaining a new veteran patient. These values can be used in future C.A.R.E. training to motivate participants to better serve veterans.

Also, a strategy for communicating these values to all VISN 8 employees should be explored. The value of improving patient satisfaction can be illustrated using this study as an example. This study can be a tool for future improvements in veteran patient service and employee training.

Boudreaux ED, Ary RD, Mandry CV, & McCabe B. (2000). **Determinants of patient satisfaction in a large, municipal ED: the role of demographic variables, visit characteristics, and patient perceptions.** *AJEM*, 18(4): 394-400.

We investigated predictors of patient satisfaction in a large, municipal emergency department (ED). Patients were telephoned 10 days post-visit, and satisfaction was assessed using a structured survey with 22 items measuring several domains, as well as the estimated length of stay. The dependent variables consisted of ratings of overall satisfaction and likelihood of recommending the ED to others. Data were obtained from 437 (38.7%) patients. Univariate statistics revealed strong relations between indicators of perceived care and both dependent variables, with weaker and mixed findings pertaining to demographics and visit characteristics. The final logistic regression predicting overall satisfaction included the following items ( $P < .05$ ): degree to which staff cared for the patient as a person, perceptions of safety, understandability of discharge instructions, nurse's technical skills, and satisfaction with wait for physician. Likelihood to recommend was associated with ( $P < .05$ ): degree to which staff cared for the patient as a person, understandability of discharge instructions, perceptions of safety, age, and insurance status. Patients' perceptions of care, rather than demographics and visit characteristics, most consistently predicted satisfaction. However, differences were observed

between the specific predictors for overall satisfaction and likelihood to recommend, providing a possible explanation for inconsistencies observed in the literature.

† Brock DM, Mauksch LB, Witteborn S, Hummel J, Nagasawa P & Robins LS. (2011). **Effectiveness of intensive physician training in upfront agenda setting.** *J Gen Intern Med.*, 26(11):1317-23.

**BACKGROUND:** Patients want all their concerns heard, but physicians fear losing control of time and interrupt patients before all concerns are raised.

**OBJECTIVE:** We hypothesized that when physicians were trained to use collaborative upfront agenda setting, visits would be no longer, more concerns would be identified, fewer concerns would surface late in the visit, and patients would report greater satisfaction and improved functional status.

**DESIGN AND PARTICIPANTS:** Post-only randomized controlled trial using qualitative and quantitative methods. Six months after training (March 2004-March 2005) physician-patient encounters in two large primary care organizations were audio taped and patients (1460) and physicians (48) were surveyed.

**INTERVENTION:** Experimental physicians received training in upfront agenda setting through the Establishing Focus Protocol, including two hours of training and two hours of coaching per week for four consecutive weeks.

**MAIN MEASURES:** Outcomes included agenda setting behaviors demonstrated during the early, middle, and late encounter phases, visit length, number of raised concerns, patient and physician satisfaction, trust and functional status.

**KEY RESULTS:** Experimental physicians were more likely to make additional elicitations ( $p < 0.01$ ) and their patients were more likely to indicate agenda completion in the early phase of the encounter ( $p < 0.01$ ). Experimental group patients and physicians raised fewer concerns in the late encounter phase ( $p < 0.01$ ). There were no significant differences in visit length, total concerns addressed, patient or provider satisfaction, or patient trust and functional status.

**CONCLUSION:** Collaborative upfront agenda setting did not increase visit length or the number of problems addressed per visit but may reduce the likelihood of “oh by the way” concerns surfacing late in the encounter. However, upfront agenda setting is not sufficient to enhance patient satisfaction, trust or functional status. Training focused on physicians instead of teams and without regular reinforcement may have limited impact in changing visit content and time use.

Brown AD, Sandoval GA, Levinton C & Blackstien-Hirsch P. (2005). **Developing an efficient model to select emergency department patient satisfaction improvement strategies.** *Annals of Emergency Medicine.* 46(1):3-10.

**STUDY OBJECTIVE:** Patient satisfaction is an important performance measure for emergency departments (EDs), but the most efficient ways of improving satisfaction are unclear. This study uses optimization techniques to identify the best possible combination of predictors of overall patient satisfaction to help guide improvement efforts.

**METHODS:** The results of a satisfaction survey from 20,500 patients who visited 123 EDs were used to develop ordinal logistic regression models for overall quality of care, overall medical treatment, willingness to recommend the ED to others, and willingness to return to the same ED. Originally, 68,981 surveys were mailed, and 20,916 were returned, representing an overall response rate of 30.3%. We then incorporated these regressions into an optimization model to select the most efficient combination of predictors necessary to increase the 4 overall satisfaction measures by 5%. A sensitivity analysis was also conducted to explore differences across hospital peer groups and regions.

**RESULTS:** Results differ slightly for each of the 4 overall satisfaction measures. However, 4 predictors were common to all of these measures: “perceived waiting time to receive treatment,” “courtesy of the nursing staff,” “courtesy of the physicians,” and “thoroughness of the physicians.” The selected predictors were not necessarily the strongest predictors identified through regression models. The optimization model suggests that most of these predictors must be improved by 15% to increase the overall satisfaction measures by 5%.

**CONCLUSION:** This study introduces the use of optimization techniques to study ED patient



satisfaction and highlights an opportunity to apply this technique to widely collected data to help inform hospitals' improvement strategies. The results suggest that hospitals should focus most of their improvement efforts on the 4 predictors mentioned above.

† Brugel S, Postma-Nilsenová M, Tates K. (2015). **The link between perception of clinical empathy and nonverbal behavior: The effect of a doctor's gaze and body orientation.** *Patient Educ Couns*, 98(10):1260-5. doi: 10.1016/j.pec.2015.08.007.

**OBJECTIVES:** Clinical empathy is considered to be one of the most important skills for medical professionals. It is primarily conveyed by nonverbal behavior; however, little is known about the importance of different types of cues and their relation to engagement and sincerity as possible correlates of perceived clinical empathy (PCE). In this study, we explored the effect of doctor's gaze and body orientation on PCE with the help of 32 video vignettes.

**METHODS:** Actors impersonating medical interns displayed different combinations of gaze and body orientation while uttering an empathetic verbal statement. The video vignettes were evaluated in terms of the perceived clinical and general empathy, engagement and sincerity.

**RESULTS:** A principal component analysis revealed a possible single-factor solution for the scales measuring the two types of empathy, engagement and sincerity; therefore, they were subsumed under general perceived empathy (GPE). An analysis of variance showed a main effect of gaze and body orientation, with a stronger effect of gaze, on GPE. We subsequently performed a linear random effects analysis, which indicated possible gender-related differences in the perception of gaze.

**CONCLUSIONS:** The outcomes of our experiment confirm that both gaze and body orientation have an influence on the GPE. The effect of gaze, however, appears to be gender-dependent: in the experiment, males were perceived as slightly more empathetic with patient-centered gaze, while for females averted gaze resulted in higher GPE scores.

**PRACTICE IMPLICATIONS:** The findings are directly relevant in the context of medical communication training. Perception of clinical empathy supports medical information transfer, diagnosis quality and other patient outcomes.

Burgio LD, Allen-Burge R, et al. (2001). **Come talk with me: improving communication between nursing assistants and nursing home residents during care routines.** *Gerontologist*, 41(4): 449-461.

Presents information on a study that examined the effects of communication skills training and the use of memory books by certified nursing assistants (CNA) on verbal interactions between CNA and nursing home residents during care routines. A staff motivational system encouraged performance and maintenance of communication skills. Compared to a control group, trained CNAs talked more, used positive statements more frequently, and gave specific instructions to patients more frequently, without increasing the time giving patients care. CNA behavior change was maintained at 2-month follow-up.

**OBJECTIVE:** To examine the effects of communications skills training and the use of memory books by Certified Nursing Assistants and nursing home residents during care routines.

**DESIGN:** Two-group (treatment/no-treatment) comparison design with an intra-group comparison component embedded in each group. Nursing home units were randomly selected for inclusion in study, and randomly assigned to treatment or control condition.

**SETTING:** Five nursing homes with an average of 120 residents on three units.

**SUBJECTS:** Certified nursing assistants (n=64); Nursing home residents (n=67). Residents were assessed on mental function (Mini-Mental Status Examination, Short Portable Mental Status Questionnaire, Functional Independence Measure) and Activities of Daily Living (ADL), and were included in the study only if they met certain criteria.

**INTERVENTION:** Baseline data on residents, staff, and their behavior were gathered for 4 weeks. During week 5, communication-memory book skill in-service workshops were conducted on the treatment units. Role-play, discussion of real-life examples, and discussion of written vignettes were part of the communication-skills training. Staff were trained in using the memory books to

increase communication among residents and between residents and staff, to increase residents' independent functioning, and to distract residents to decrease disruptive behaviors. Memory books contain images and brief sentences that provide cognitive stimulation to patients and facilitate communication with staff and others. After the initial in-service training, residents were given a personalized, 12-page memory book with biographical, orientation, and daily schedule information. Hands-on training in communication and memory book use continued for 4 weeks. Supervisory staff and researchers observed each CNA once a day during their shift and provided feedback on their use of the communication skills taught during the in-service (staff motivational system). Supervising LPNs were also observed by the project manager and were given feedback on their supervision of the CNAs. Thirty-nine CNAs in the treatment group were taught to monitor and record their skill performance to both track their skill-usage and to motivate them. Trained CNAs who met 80% of the skills criteria received public recognition on the CNA honor role once a week and were entered into a lottery for a prize.

**DATA COLLECTION:** After the 4-week hands-on training, the next 8 weeks included evaluation of the intervention's effectiveness and continued use of a staff motivational system. Measures included the CNA Communication Skills Checklist (CSC) and the Observations of the LPN's Supervisory Activities (OLSA). Follow-up data were collected two months post-intervention. Computer-Assisted Behavioral Observation System (CABOS) hardware and software were used to record and analyze behavior during care-giving interactions.

**DATA ANALYSIS:** CSC outcome data included the rate of CNA use of specific, one-step instructions, positive statements, biographical statements, multiple-step instructions, total duration of care. CABOS outcome data included total percentage of time of resident coherent verbal interaction, staff speech directed to resident, rate per hour of positive statements made by residents or CNAs. Descriptive statistics were used to assess the treatment delivery and enactment. A 2 (group) X 3 (time) ANOVA assessed behavior change of staff and residents at baseline, post-intervention training, and during the 8-week evaluation period. A 2(group) X 2(time) ANOVA assessed behavior change between the 8-week evaluation period and the 2-month post-intervention follow-up.

**FINDINGS:** The majority of CNAs (92%) passed a final evaluation with a performance score of at least 80% on the CSC. There were no baseline differences between the treatment and control groups on the CSC. The 2 X 3 ANOVA revealed significant main effects for group and time and a significant group X time interaction, indicated that CNAs in the treatment group improved their communication skills compared to the control group and over time. Treatment group CNAs increased their use of positive statements, time spent talking, use of specific one-step instructions, and they used fewer multi-step instructions. No differences were found in the use of biographical statements or time spent in care giving. Residents were more independent in self-care at 2-month follow-up as assessed by the FIM.

**CONCLUSIONS:** Communication skills training, along with a staff motivational system, improved CNAs ability to communicate effectively with nursing home residents without increasing the time delivering daily care.

Bursch B, Beezy J, et al. (1993). **Emergency department satisfaction: what matters most?** *Annals of Emergency Medicine*, 22(3): 586-591.

**OBJECTIVE:** To determine the effect of art of care, and wait time on patient satisfaction with Emergency Department (ED) services.

**DESIGN:** Retrospective telephone survey.

**SETTING:** The Kaiser Permanente Medical Care Program in Southern California.

**SUBJECTS:** All patients (433) patients who went to the Emergency Department in a two week period in 1991. 258 completed interviews.

**MEASURES:** A telephone interview that involved closed- and open-ended questions concerning aspects of patient care satisfaction and demographics.

**RESULTS:** Thirteen items correlated positively with overall patient satisfaction: health plan member's age, number of years as a member, perceptions of staff as organized, staff introducing themselves, knowing how to get help in a hospital bed, getting self-care directions on discharge, perceptions of the nurses as caring, being informed as to what was happening by the nurses, the

family being informed about the condition, the staff providing help in contacting a relative, perceptions of physicians as caring, being informed by the physicians as to what was happening, and satisfaction with the amount of time before care was given. The most important factor was the amount of time taken before the patient was cared for.

CONCLUSIONS: Informing the patient of the point of initiation of care or wait time, even if not by the doctor but by the nurse, may increase patient satisfaction.

Bylund CL & Makoul G. (2005). **Examining empathy in medical encounters: an observational study using the empathic communication coding system.** *Health Communication*, 18(2), 123-140.

Educators, researchers, clinicians, and patients often advocate empathy in the physician-patient relationship. However, little research has systematically examined how patients present opportunities for physicians to communicate empathically and how physicians respond to such opportunities. The Empathic Communication Coding System was used to investigate empathic opportunity-response sequences during initial visits in a general internal medicine clinic. This study focuses on 100 visits during which patients created at least 1 explicit empathic opportunity. Overall, patients presented 249 empathic opportunities in these 100 visits; physicians most often responded by acknowledging, pursuing, or confirming the patient's statement. The mean length of empathic opportunity-response sequences was 25.8 sec; sequences tended to be longer in duration when the physician used a more empathic response. Positively valenced empathic opportunities generated a more empathic response than did negatively valenced empathic opportunities. However, there was no relation between the emotional intensity of empathic opportunities and the level of empathy in subsequent physician responses. Further research should examine patient preferences and outcomes associated with varying levels of empathic responses.

Calvin AO, Frazier L & Cohen MZ. (2007). **Examining older adults' perceptions of health care providers: identifying important aspects of older adults' relationships with physicians and nurses. Older adults want to feel cared for, respected, and informed.** *Journal of Gerontological Nursing*. 33(5):6-12.

This article describes older adults' conversations about their relationships with health care providers. Focus group participants (N = 23) were from three ethnic groups (Black, White, and Hispanic) and ages 53 to 92. All but three of the participants were women. Content analysis revealed an overarching theme of genuine caring and three sub-themes: interest in patients' well-being, respectful dialogue, and sharing of information. Older adults' perceptions of genuine caring by physicians and nurses did not differ by ethnicity. Older adults want to engage in a caring, respectful, and educational relationship with their health care providers, which is consistent with fundamental professional values.

Caris-Verhallen WM, Kerkstra A, Bensing JM & Grypdonck MH. (2000). **Effects of video interaction analysis training on nurse-patient communication in the care of the elderly.** *Patient Education & Counseling*, 39(1): 91-103.

Describes an empirical evaluation of communication skills training for nurses in elderly care. The training program was based on Video Interaction Analysis and aimed to improve nurses' communication skills such that they pay attention to patients' physical, social, and emotional needs and support self-care in elderly people. The effects of the training course were measured in an experimental and control group. Independent observers rated them, by comparing videotapes of nursing encounters before and after training. 40 nurses participated in 316 videotaped nursing encounters. Multilevel analysis was used to take into account similarity among same nurse encounters. It was found that nurses who followed the training program provided the patients with more information about nursing and health topics. They also used more open-ended questions. In addition, they were rated as more involved, warmer, and less patronizing. Due to limitations in the study design, it could not be demonstrated that these findings can entirely be ascribed to the training course. Further research, incorporating a randomized controlled design and larger sample sizes, is recommended to determine whether

the results can be attributed to this specific type of training.

**OBJECTIVE:** To determine the effects of Video Interaction Analysis communication training on the communicative behavior of nurses and patients in elderly care.

**DESIGN:** Quasi-experimental, Pre-test/ Post-test, Treatment group/ Control group design. Groups were not randomly assigned but there were no significant differences between groups on background variables.

**SETTING:** A home care organization and a nursing home.

**SUBJECTS:** Treatment group: n=24 nurses; Control group: n=23 nurses (who received training later). Nurses recruited patients subjects for videotaped encounters, patient n=241.

**INTERVENTION:** Nurses participated in a series of communication skills trainings. Training focused on developing nurses' awareness of the physical, social, and emotional needs of the elderly, verbal communication techniques (i.e. "structuring" and "exploring patients' ideas and opinions"), using active listening skills (paraphrasing, "mhm") to enhance patients' feelings of competence, asking open ended questions, and nonverbal behaviors (eye contact, leaning forward, smiling, head nodding, touch). They spent 2 days learning about communication theory, communication with the elderly, Video Interaction Analysis, and role-playing nurse-patient interactions with trained actors. Pairs of nurses then spent 6 Video Interaction Analysis sessions watching videotape of their own behavior during care giving and discussed their behaviors with the trainer. Learning took place in 3 ways: the participants' review of their own performance, feedback from the trainer, and peer comments. Video Interaction Analysis was meant to improve nurses' communication skills so that they would pay more attention to patients' physical and social needs, facilitate self-care in elderly patients, and support patients in finding their own solutions to problems. During the 6-week periods between sessions, participants practiced their new skills and recorded a new caring interaction, which they analyzed on their own before the next session. At the end of course, the participants held a group discussion about their experiences and evaluated the course structure, process, and their personal results.

**DATA COLLECTION:** Before commencing training, participants videotaped care giving encounters to provide pre-test data (treatment group = 87 encounters, control group = 69 encounters). Encounters had a mean duration of 18 minutes. Post-test data included 87 videotaped encounters for the treatment group and 73 for the control group. Two independent observers who were blinded to the experimental condition measured nurse-patient communication. They used the CAMERA computer system to code behavioral interactions. Verbal communication was coded using Roter's Interaction Analysis System. Clusters of behavior included social communication, affective communication, communication that structures the encounter, communication about nursing and health, and communication about lifestyle and feelings. Proportion of the time spent engaging in nonverbal behaviors--eye contact, affirmative nodding, smiling, leaning forward, and affective and instrumental touch-- were also coded. General affective impression was coded on 6-point scales rating irritation, nervousness, assertiveness, interest, warmth, patronizing, and involvement.

**DATA ANALYSIS:** Proportion of care giving time spent in verbal and nonverbal communicative behaviors was compared pre- and post-intervention within the treatment and control groups. Hierarchical linear modeling was used to analyze the data.

**FINDINGS:** In the treatment group, significant differences were found for verbal disagreement (decreased), information provision (increased), and counseling and advice (decreased), and open-ended questions (increased) when comparing the pre-test to the post-test. In post-test, nurses in the treatment group smiled less often and leaned forward less often than at pre-test. At post-test, nurses in the treatment group expressed more positive affect, including more interest, warmth, and involvement and less patronizing. Nurses in the treatment group improved more in showing interest and warmth than the control group, but did not significantly improve in the other nonverbal behaviors, affect, or verbal communication compared to the control group. Patients interacting with the treatment group nurses showed less disagreement, gave more information, and produced their own solutions more often at post-test. In general, results were more significant in the home care setting than in the nursing home setting, although there was increased use of structuring communication skills among treatment group nurses in the nursing home setting. No significant differences were found between the treatment and control groups



when mean differences between pre- and post-test results were compared.

**CONCLUSIONS:** Nurses in the treatment group, especially those in home care, showed significant improvement in communication skills after receiving the intervention. Though not significant, changes in the positive direction also occurred in the control group, indicating cross-contamination or bias introduced by virtue of participation in the study. Weaknesses in the study design limit the ability to draw conclusions that Video Interaction Analysis improved nurse communication skills, though the results suggest that this method is helpful for training nurses in communication skills.

Chang B, Uman G, et al. (1984). **The effect of systematically varying components of nursing care on satisfaction in elderly ambulatory women.** *Western Journal of Nursing Research*, 6(4): 367-379.

**OBJECTIVE:** To identify which elements of nurse practitioner care augment elderly women's assessment of health care in the areas of their general and specific satisfaction.

**DESIGN:** An 8 cell experimental design was used. Questionnaires were given to examine four parts of nursing care determined to be necessary in helping individuals care for themselves and one aspect of consumer measurement, which was consumer satisfaction. Orem's (1980) self-care concepts for nursing practice were used as the theoretical basis for the study.

**SETTING:** Twenty-six senior citizen nutrition sites in West Los Angeles and the San Fernando Valley.

**SUBJECTS:** Two hundred and sixty-eight volunteers with a mean age of 70.9.

**MEASURES:** Patients viewed one of 8 tapes in which three parts of care including technical quality, psychosocial, and patient participation, were manipulated to show differing high or low levels while courtesy of care was kept stable. Patients were administered a questionnaire assessing baseline data of subject characteristics, attitudes and expectations regarding health care prior to viewing the videotapes. After watching the tapes, a questionnaire was completed that focused on overall and specific satisfaction.

**RESULTS:** Global satisfaction was impacted by the type of technical quality, psychosocial care, and patient participation in treatment. Variance in global satisfaction factor scores by the three parts of care was low. Patient satisfaction was largely influenced by pre-existing satisfaction with health care. Older subjects expressed greater satisfaction with care than younger patients.

**CONCLUSIONS:** This sample was able to differentiate between high and low levels of care. High technical care, a high psychosocial environment, and high patient participation were related to greater patient satisfaction. Nursing education should stress technical knowledge skills, and the psychosocial part of care. Nurses should encourage the patient to help plan their own self-care.

Chen PW. (2008). **Taking time for empathy.** *New York Times – Doctor and Patient*, September 26, 2008.

Clever SL, Jin L, Levinson W, & Meltzer DO. (2008). **Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable.** *Health Services Research*, 43:5, Part I (Oct 2008): 1505-1519.

**OBJECTIVE:** To determine the relationship between physicians' communication behaviors and patients' overall satisfaction with hospital care using a novel instrumental variable to address possible confounding of this association by patient attributes.

**DATA SOURCES/STUDY SETTING:** Administrative records and postdischarge survey data were obtained from patients discharged from the General Medicine service at an urban tertiary-care academic hospital between July 1, 1997 and June 30, 2000. Administrative data included comorbidities, demographic data, and payer status. In the discharge survey, patients rated their attending physician on four communication behaviors, other aspects of their hospital stay, and their overall hospital care.

**STUDY DESIGN:** The primary outcome was patients' ratings of their overall satisfaction with hospital care, and the primary independent variable was patients' ratings of their physicians' communication behaviors. To remove possible confounding of the association between patient ratings of physician communication and overall satisfaction by other patient-specific attributes,



we created an instrumental variable (IV) in a two-stage linear regression. The IV was the mean of the communication ratings given to each physician by the other patients cared for by that physician.

**PRINCIPLE FINDINGS/CONCLUSIONS:** Three thousand one hundred and twenty-three patients were included in the analysis. In the ordinary least squares regression, there was a significant positive relationship between overall satisfaction and overall ratings of attendings' communication behaviors, with an increase in overall satisfaction of 0.58 points on a 5-point scale for each 1-point increase in overall attendings' communication behaviors,  $p < 0.001$ . This relationship was maintained but attenuated in the IV regression, with a coefficient of 0.40,  $p = 0.046$ . Although we find that the relationship between patient communication ratings and overall patient satisfaction may be confounded by patient-level factors, we nevertheless continue to find evidence of a statistically significant and sizable relationship between physicians' communication behaviors and overall patient satisfaction after controlling for such factors.

Corbett G & McGuigan T. (2008). **Patient satisfaction: Gillian Corbett and Tricia McGuigan report the results of a survey of patients' responses to the care they receive from minor/major injury/illness nurse treatment service nurses.** *Emergency Nurse*, 16(3):26-35.

Authors report the results of a survey of patients' responses to the care they receive from minor/major injury/illness nurse treatment service nurses. The survey results indicate an improvement in patient satisfaction over several components of care, including patient information, since the Picker Institute surveys were conducted in 2005. When asked about receiving information on condition and treatment in 2005, 46 per cent of patients indicated that they had been given enough information. When asked the same question for the see-and-treat survey in 2007, 85 per cent of patients expressed this opinion. The survey revealed that patients' satisfaction with the see-and-treat services was high and independent of waiting times. When compared with middle grade and consultant doctors, nurses performed well and, according to patients, were knowledgeable and competent, and generally had good communication skills. While nurses achieved high scores on all subscales of the questionnaire, results suggest that lack of professional confidence is an issue worth addressing.

Coulehan JL, Platt FW, Egener B, Frankel R, Lin CT, Lown B, et al. (2001). **"Let me see if I have this right...": words that help build empathy.** *Annals of Internal Medicine*, 135(3) 221-227.

Emphasized the importance of the choice of words and sentences in the facilitation of empathy in the medical encounter. Difference between empathy and sympathy; Components of empathic communication; Potential empathic opportunities; Guidelines for clinical empathy in the cross-cultural setting.

DeLemos D, Chen M, Romer A, Brydon K, Kastner K, Anthony B & Hoehn KS. (2010). **Building trust through communication in the intensive care unit: HICCC.** *Pediatric Critical Care Medicine*. 11 (3): 378-384.

**OBJECTIVE:** The goal of this study was to explore the role of communication in building trust between intensivists and parents in the pediatric intensive care unit.

**METHODS:** Semistructured qualitative interviews were administered to English-speaking parents of children who were admitted to the pediatric intensive care unit for at least 48 hrs. Parents were asked about the factors impacting trust and communication in the pediatric intensive care unit. Qualitative data were managed with NVIVO software (QSR International, Southport, UK) and analyzed for themes.

**RESULTS:** Participants were 122 parents (41% black, 40% white). Most parents articulated that communication is integral to building trust. Specifically, parents described that they wanted healthcare workers to communicate in ways that were Honest, Inclusive, Compassionate, Clear and Comprehensive, and Coordinated, which can be summarized using the acronym, HICCC. In addition, nonwhite parents were more likely than white parents to report instances when they felt doctors did not listen to them ( $p = 0.0083$ ). Parents from minority groups reported instances of self-experienced or observed discrimination in healthcare with greater frequency than white

parents. When asked to identify their pediatric intensive care unit doctor, 46% of parents were either unable to do so or named doctors from other hospital departments.

CONCLUSIONS: Communication is vital to building trust in the pediatric intensive care unit. Developed from parents' own observations and perspectives, HICCC is an accessible framework that can help doctors to remember what parents value in communication in the acute care setting. In addition, pediatric intensivists would benefit from targeted cultural competency training to reduce physician bias.

DeMatteo MR. (2003). **Future directions in research on consumer-provider communication and adherence to cancer prevention and treatment.** *Patient Education and Counseling*, 50: 23-26.

The goal of this paper is to examine emerging issues in consumer-provider communication and patient adherence to cancer prevention, screening, diagnosis, treatment, and coping with survivorship. Many factors that have been shown to affect adherence can be supported or hindered by provider-patient communication, including the provider-patient relationship, patients' beliefs, social and cultural norms, family and social support, mood, and behavioral management. Six research questions are posed, and substantive & methodological recommendations are offered for empirical research on the measurement & achievement of patient adherence.

Denham CR, Dingman J, Foley ME, Ford D, Martins B, O'Regan P, & Salamendra A. (2008). **Are you listening...are you really listening?** *Journal of Patient Safety*. 4(3):148-161.

OBJECTIVES: This is the first of a series of articles addressing the concepts, tools, and resources that can be applied to an enormous performance gap in verbal communication among patients, families, frontline caregivers, physicians, and health care-organization administrative and governance leaders.

METHODS: This first paper takes a "concept-centric" approach by laying the knowledge foundation necessary to improve communication. It references how such concepts may be applied to accelerate and improve adoption of best practices such as the National Quality Forum-Endorsed Safe Practices for Better Healthcare-2006 Update. The second article of the set is a "safe practice-centric" approach to illustrate how listening concepts, tools, and resources may be leveraged to improve patient safety through the National Quality Forum (NQF) Safe Practices.

RESULTS: This first article defines and supports recognition of key concepts including human factors performance, authority gradient factors, caregiver-to-caregiver barriers, health literacy factors, and the art and science of active listening.

CONCLUSION: Use of these concepts can have terrific impact on preventable patient harm & optimization of care.

Doig G. (2004). **Responding to formal complaints about the emergency department: Lessons from the service marketing literature.** *Emergency Medicine Australasia*. 16(4):353-360.

The ability to respond to formal complaints is a necessary part of emergency medicine. In spite of the significance of formal complaints there is little guidance within the medical literature to understand why patients complain or how to provide satisfaction to individuals who complain. Practitioners are usually left to their own devices in the style and substance of complaint responses even when working within a defined complaint management system. This article draws on relatively abundant literature in the service marketing field to provide an understanding of dissatisfaction, complaining and complaint handling. Having developed an appropriate theoretical framework the article provides guidance for applying these concepts in dealing with formal complaints

Easter DW, & Beach W. (2004). **Competent patient care is dependent upon attending to empathic opportunities presented during interview sessions.** *Current Surgery*, 61(3):313-318.

OBJECTIVE: Core competencies in surgical education and clinical care rely on effective patient-physician communication. We aim to develop quantitative and empirical tools for understanding

critical communication tasks during patient interviews.

**METHODS:** Residents in surgical training and attending physicians were separately video recorded during stressful, first visit oncology patient interview sessions. Taped sessions (n = 16) were analyzed in detail to identify and label patient-initiated actions (PIAs), or “empathic opportunities,” that call for recognition or action from the caregiver. Doctor-responsive actions (DRAs) were labeled as matching to, or missing from, each empathic opportunity. Missed empathic opportunities occurred when a PIA did not have an associated DRA. Pre-session and post-session surveys queried the patient’s perception of how well their health-care needs were met.

**RESULTS:** Resident trainees and attending physicians missed 70% of 160 clearly identified empathic opportunities. There was no clear association with the level of physician training. This pilot study did not have enough power to discern differences in patient satisfaction.

**CONCLUSIONS:** Physicians are often not very attentive to empathic opportunities offered by patients. Individual feedback and training regarding empathic opportunities in recorded patient communication encounters may improve resident and physician core competencies. These improvements may affect patient satisfaction related to these encounters.

Elder R, Neal C, Davis BA, Almes E, Whitley L & Littlepage N. (2004). **Patient satisfaction with triage nursing in a rural hospital emergency department.** *Journal of Nursing Care Quality.* 19(3):263-268.

This study examined what relationships or differences exist between patient and nurse characteristics, satisfaction with triage nurse caring behaviors, general satisfaction with the triage nurse, and intent to return to a rural hospital emergency department (ED). The ED, located at a 401-bed teaching hospital in a small southern city, averages 28,000 visits annually. Samples of ED nurses (N = 11) and ED patients (N = 65) were asked to respond to demographic forms and the Consumer Emergency Care Satisfaction Scale (CECSS) Adapted. Findings indicated that the nurse’s acuity rating and the patient’s perception of condition had a positive relationship. The patient’s perception of condition, patient satisfaction, and caring satisfaction were predictors of intent to return. When patients perceived themselves as seriously ill or injured, they expressed less intent to return to that ED.

† Flickinger TE, Saha S, Roter D, Korhies PT, Sharp V, Cohn J, Moore RD, Ingersoll KS, Beach, MC. (2015). **Respecting patients is associated with more patient-centered communication behaviors in clinical encounters.** *Patient Educ Couns,* pii: S0738-3991(15)30057-4. doi: 10.1016/j.pec.2015.08.020.

**OBJECTIVE:** Attitudes towards patients may influence how clinicians interact. We investigated whether respect for patients was associated with communication behaviors during HIV care encounters.

**METHODS:** We analyzed audio-recordings of visits between 413 adult HIV-infected patients and 45 primary HIV care providers. The independent variable was clinician-reported respect for the patient and outcomes were clinician and patient communication behaviors assessed by the Roter Interaction Analysis System (RIAS). We performed negative binomial regressions for counts outcomes and linear regressions for global outcomes.

**RESULTS:** When clinicians had higher respect for a patient, they engaged in more rapport-building, social chitchat, and positive talk. Patients of clinicians with higher respect for them engaged in more rapport-building, social chitchat, positive talk, and gave more psychosocial information. Encounters between patients and clinicians with higher respect for them had more positive clinician emotional tone [regression coefficient 2.97 (1.92-4.59)], more positive patient emotional tone [2.71 (1.75-4.21)], less clinician verbal dominance [0.81 (0.68-0.96)] and more patient-centeredness [1.28 (1.09-1.51)].

**CONCLUSIONS:** Respect is associated with positive and patient-centered communication behaviors during encounters.

**PRACTICE IMPLICATIONS:** Clinicians should be mindful of their respectful attitudes and work to foster positive regard for patients. Educators should consider methods to enhance trainees’ respect in communication skills training.

Ford WS, & Snyder OJ (2000). **Customer service in dental offices: analyses of service orientations and waiting time in telephone interactions with a potential new customer.** *Health Communication*, 12(2): 149-172.

Examined service practices engaged by dental office staff interacting over the telephone with a potential new customer. The goals of the study were to determine whether the staff displayed customer-oriented and control-oriented service communication behaviors and to examine the relation between these service behaviors and waiting time required of customers. Structured observational data were collected in phone encounters with staff in 84 dental offices. Approximately 40% of the staff engaged in the customer-oriented behavior of inviting the customer to share questions or concerns, and 31% exhibited the control-oriented behavior of reciting promotional pitches on behalf of the dental office. Six other communication behaviors were observed with less frequency. Staff who made customers wait on the line longer were more likely to use promotional pitches. The telephone script is appended.

**OBJECTIVE:** To determine the extent to which dental office staff engages in communication behaviors with customer orientation / control orientation during initial telephone interactions with potential new customers, and to determine the relationship between staff communication orientation and customer waiting time.

**DESIGN:** cross-sectional; the researchers called the dental offices and used a script to engage in a conversation about dental services.

**SETTING:** 84 dental offices in a medium metropolitan area in the Midwest.

**SUBJECTS:** 84 dental office staff.

**DATA COLLECTION:** Calls were recorded and timed. Communication behaviors were coded for 4 types of customer oriented communication behaviors: chit chat, laughter, invitations to speak, and listening responses (reflecting/paraphrase and following (mhm, okay), for 4 types of control oriented communication behaviors: promotional pitches, commitment prompts, talkovers, and cutoffs, and for 2 types of waiting while on the phone (extra rings, being on hold).

**DATA ANALYSIS:** Communication behavior frequencies were calculated using descriptive statistics.

**FINDINGS:** 40.5% of the office staff invited customers to speak, a form of customer-oriented communication. Some used laughter (22.6%). Few used chitchat (3.6%) or listening responses (8.3%). Control-oriented behaviors were more frequently used than customer-oriented behaviors: promotional pitches (31%), commitment prompts (10.7%), talkovers (7.1%), and cutoffs (8.3%). Though there were no significant inter-item correlations between any of the two types of behaviors, 27.4% of the staff used both control- and customer-oriented communication behaviors. However, another 27.4% of the staff did not display any of the behaviors at all. Most waiting time occurred during extra rings, though the phone never rang more than 3 times. Only 10.4% of staff put the caller on hold. There was no association between waiting through extra rings and being placed on hold. Only promotional pitches were significantly, positively associated with waiting time.

**CONCLUSIONS:** Dental office staff seemed to rely on a communication routine, rather than on customer-oriented communication behaviors, when speaking with potential new patients on the phone. The authors recommended that receptionist staff in healthcare organizations use more personalized communication behaviors such as asking customers to ask questions or indicating that they are listening by saying "mhm" in order to let customers know they are being paid attention.

Fox S. (2006). Online health search 2006. Pew Internet & American Life Project © 2006 Pew Internet & American Life Project.

This Pew Internet & American Life Project report is based on the findings of a daily tracking survey on Americans' use of the internet. All numerical data was gathered through telephone interviews conducted by Princeton Survey Research Associates between August 1-31, 2006, among a sample of 2,928 adults, aged 18 and older. For results based on the total sample, one can say with 95% confidence that the error attributable to sampling and other random effects is +/- 2%. For results based on internet users (n=1,990), the margin of sampling error is +/- 3%.



Eighty percent of American internet users, or some 113 million adults, have searched for information on at least one of seventeen health topics. The percentage of internet users who search for health information has been stable over the past four years, even as the internet population has grown and broadband connections at home have become the norm. As in 2002 and 2004, certain groups of internet users in 2006 are the most likely to have sought health information online: women, internet users younger than 65, college graduates, those with more online experience, and those with broadband access at home.

Fox S & Rainie L. (2008). **The engaged e-patient population** Washington, DC. Pew internet and American life project: Available at: [http://www.pewinternet.org/pdfs/PIP\\_Health\\_Aug08.pdf](http://www.pewinternet.org/pdfs/PIP_Health_Aug08.pdf)

This latest Pew Internet Project survey confirms that information gathering has become a habit for many Americans, particularly those in the 55% of households with broadband connections. Home broadband has now joined educational attainment, household income and age as the strongest predictors of internet activity. For example, 78% of home broadband users look online for health information, compared with 70% of home dial-up users. Home broadband users are twice as likely as home dial-up users to do health research on a typical day—12% vs. 6%. High-speed, always-on connections enable frequent and in-depth information searches, which is particularly attractive if something important is at stake.

† Gountas S, Gountas J, Soutar G & Mavondo F. (2014). **Delivering good service: personal resources, job satisfaction and nurses' 'customer' (patient) orientation.** *Journal of Advanced Nursing*, 70(7), 1553–1563.

**Aims:** To explore the complex relationships between nurses' personal resources, job satisfaction and 'customer' (patient) orientation.

**Background:** Previous research has shown that nursing is highly intensive, emotionally charged work, which affects nurses' job performance and their customer orientation as well as patient or 'customer' satisfaction. This study contributes to the literature by examining how nurses' personal resources relate to their personal satisfaction and customer orientation and the relationships between them. Specifically, this study explores the effects of two facets of emotional labour (deep acting and surface acting), empathic concern, self-efficacy and emotional exhaustion on personal job satisfaction and customer orientation. We also test the moderating effects of inauthenticity and emotional contagion.

**Design:** A quantitative survey.

**Method:** Data were collected through a self-completion questionnaire administered to a sample of 159 Australian nurses, in a public teaching hospital, in 2010. The data were analysed using Partial Least Square analysis. **Results:** Partial Least Square analysis indicates that the final model is a good fit to the data (Goodness of Fit = 0.51). Deep acting and surface acting have different effects (positive and negative) on job satisfaction and 'customer' orientation, self-efficacy has a positive effect on both and emotional exhaustion has a positive effect on customer orientation and a negative effect on job satisfaction. The moderating effects of emotional contagion and empathic concern, in the final model, are discussed.

**Conclusions:** Understanding the complex interactions between personal resources, job satisfaction and customer orientation helps to increase service providers' (nurses in this study) personal satisfaction and 'customer' orientation particularly in difficult contexts.

Groopman J. (2007). **How doctors think.** Houghton Mifflin Company: NY.

On average, a physician will interrupt a patient describing her symptoms within eighteen seconds. In that short time, many doctors decide on the likely diagnosis and best treatment. Often, decisions made this way are correct, but at crucial moments they can also be wrong -- with catastrophic consequences. In this myth-shattering book, Jerome Groopman pinpoints the forces and thought processes behind the decisions doctors make. Groopman explores why doctors err and shows when and how they can -- avoid snap judgments, ease uncertainty, communicate effectively, and deploy other skills that can profoundly impact our health. This book is the first to describe in detail the warning signs of erroneous medical thinking and reveal how new technologies may actually hinder accurate diagnoses. *How Doctors Think* offers direct,



intelligent questions patients can ask their doctors to help them get back on track. Groopman draws on a wealth of research, extensive interviews with some of the country's best doctors, and his own experiences as a doctor and as a patient. He has learned many of the lessons in this book the hard way, from his own mistakes and from errors his doctors made in treating his own debilitating medical problems. *How Doctors Think* reveals a profound new view of twenty-first-century medical practice, giving doctors and patients the vital information they need to make better judgments together.

Hadlow J, & Pitts M. (1991). **The understanding of common health terms by doctors, nurses and patients.** *Social Science & Medicine*, 32(2): 193-196.

**OBJECTIVE:** To assess understanding of common medical and psychological terms among three groups: doctors, health care support staff, and patients.

**DESIGN:** Questionnaire survey.

**SETTING:** East Kent, England.

**SUBJECTS:** 40 doctors (20 GP & 20 Psychiatrists), 60 health support staff and 120 patients.

**MEASURES:** Twelve-item, multiple choice questionnaire comprised of common medical terms with four definitions to choose from.

**RESULTS:** Significant differences in levels of understanding were found between these groups. The widest gap in doctor-patient understanding was shown for common psychological terms. The greatest discrepancies were between doctors and patients with other health support staff falling in the middle.

**CONCLUSIONS/RECOMMENDATIONS:** Health terms have both a clinical and lay meaning. Communication between doctor and patient is an important factor contributing to the effectiveness of medical care. It is clear that common terms have different and often potentially misleading meanings for patients. This could lead to poor satisfaction, adherence, and health outcomes.

Hall MF. (1996). **Keys to patient satisfaction in the emergency department: results of a multiple facility study.** *Hospital & Health Services Administration*, 41(4): 515-533.

**ABSTRACT:** Patient satisfaction is a significant issue for emergency departments. The special nature of the emergency encounter calls for a sound understanding of the factors that influence patient satisfaction. This study uses a national sample of emergency departments to identify specific elements that increase the likelihood of patients recommending the facility. We find that demographic variables such as age and sex do not significantly influence the decision to recommend. Nursing/staff items, physician issues, and waiting time are the key factors that drive satisfaction with emergency departments.

**OBJECTIVE:** To identify the factors which are most likely to influence a patient's decision to recommend an emergency department to others.

**DESIGN:** Cross-sectional, random, mail survey.

**SETTING:** 187 Emergency Departments from the Press, Ganey Associates database.

**SUBJECTS:** 17,644 patients who visited 187 emergency departments and returned surveys.

**DATA COLLECTION:** Patients were sent surveys 3-4 days after treatment in emergency departments. Surveys items covered aspects of registration, nurses, emergency staff doctors, medical tests, treatment of family or friends, and overall ratings of the emergency department experience. Items were rated on a 5-point Likert scale from "very good" to "very poor."

**DATA ANALYSIS:** Factor analysis yielded four primary factors: "nursing and staff," "doctors," "waiting and convenience," and "test and treatment." Regression analysis was used to assess the items associated with patient satisfaction.

**FINDINGS:** The nursing/staff factor explained 53.4% of the variance. Neither age nor sex was associated with patient satisfaction. Emergency department size and number of patient visits did not affect patient satisfaction. Features of nurses' communication with patients affected patient satisfaction and patient assessment of nurses' technical skill, including "nurses took your problem seriously," "nurses' concern to keep you informed about your treatment," and "staff cared about you as a person." Communication about waiting time and delays was also important for patient satisfaction.

Hanson JL. (2008). **Shared decision making – have we missed the obvious?** *Archives of Internal Medicine*. 168(13):1368-1370.

Describes eight myths about shared decision making e.g., everyone knows what it is, there is only one approach, physicians alone drive it, most physicians would engage in shared decision making if they had the time, we don't have the time, most patients would rather the physician tell them what to do.

Hausman A. (2001). **Taking your medicine: relational steps to improving patient compliance.** *Health Marketing Quarterly*, 19(2) 49-71.

Patient non-compliance with physicians' instructions is a major problem that costs billions of dollars each year. This study supports a significant role for communication, both as a form of information exchange and social support, and participative decision-making in improving patient compliance. These results, based on structural equation modeling, also support the interaction of communication and participative decision-making positively affecting compliance. Results suggest that one-way communication from physician to patient and patient education will not solve compliance problems by themselves. Instead the solution revolves around open, bi-directional information exchange, active listening by both parties, and truly informed consent on the part of patients.

Hay MC, Strathmann C, Lieber E, Wick K & Giesser B. (2008). **Why patients go online: multiple sclerosis, the internet, and physician-patient communication.** *Neurologist*, Nov;14(6):374-81

**BACKGROUND:** The online information seeking of multiple sclerosis (MS) patients, their reasons for doing so, and its importance for physician-patient communication have not been described. **METHODS:** Patients (n = 61) presenting for the first time at an MS clinic from December 2003 to July 2005 were interviewed pre- and post-appointment and administered standard measures of pain and health quality of life. Consultations were audio recorded. Quantitative data were analyzed in light of qualitative data.

**RESULTS:** Eighty-two percent of patients reported gathering medical information online before their first appointment; 36% discussed this information with their physician. Qualitative reasons for Internet information seeking and for not communicating it show some signs of wariness of health care potentially leading to non-adherence.

**CONCLUSIONS:** Most MS patients are informed by online information, but are unlikely to discuss that research with physicians for reasons that may have implications for patient adherence.

Huller CR, McMillan JJ, et al. (2000). **Caregivers' predispositions and perceived organizational expectations for the provision of social support to nursing home residents.** *Health Communication*, 12(3): 277-299.

This article presents the results of an investigation of caregivers' (nurses and nurse assistants) provision of supportive communication to nursing home residents. Ss completed measures of supportive predispositions, perceived organizational attitudes toward provision of support, role conflict, and burnout. Five primary conclusions are drawn from the data: (1) caregivers value providing affective over instrumental support; (2) caregivers believe they place more importance on supportive communication than their organizations; (3) role conflict is emotionally exhausting, but does not affect caregivers' self-evaluations or perceptions of residents; (4) caregivers' depersonalization of patients is related to their desire to communicate instrumental support; and (5) caregivers feel more accomplished when they believe their organization values supportive communication with patients. The implications of these findings for social support, caregivers' burnout, and nursing homes are discussed.

**OBJECTIVES:** To examine caregivers' predispositions toward the provision of supportive communication to nursing home residents; to examine whether caregivers experience role conflict regarding the provision of social support to residents; to assess the relationships between caregiver predisposition and the 3 dimensions of burnout (depersonalization, emotional exhaustion, decreased personal accomplishment); to assess the relationships between caregivers' perceived organizational expectations of supportive communication and the 3

dimensions of burnout.

DESIGN: Cross-sectional survey.

SETTING: 7 Southeastern nursing homes.

SUBJECTS: Nurses (n=200)/nurse assistants (n=358) [only 61 nurses and 49 nurse assistants returned surveys].

DATA COLLECTION: Participants completed the Social Support Behaviors Scale (a 5-point Likert-type scale). The scale measured caregivers' attitudes toward the provision of social support and their perceptions of their organizations' attitudes toward the provision of social support. The 5 types of social support measured were: emotional, socializing, practical, financial, and giving advice. Role conflict was measured by the absolute value in the difference between caregivers' predisposition and perceived organizational attitude toward provision of social support. The Maslach Burnout Inventory (a 7-point Likert-type scale) was used to measure burnout.

DATA ANALYSIS: The mean predisposition of the caregivers for provision of each dimension of social support was calculated. Student's t-tests were used to compare means and determine significant differences between preferences. Similar analyses were used to identify significant differences between caregivers' predispositions and perceived organizational attitudes to assess role conflict. Role conflict scores for each dimension of social support were correlated with each of the 3 dimensions of burnout. Correlations were also calculated between caregivers' predispositions, perceived organizational attitudes, and burnout.

FINDINGS: Caregivers were more highly predisposed toward affective forms of social support (emotional, advice, and social) than toward instrumental forms (practical and financial). Role conflict was significant for each dimension of social support. Increases in role conflict regarding advising, emotional support, financial support, and practical support were each significantly correlated to the emotional exhaustion dimension of burnout. Predispositions toward provision of financial and practical support were each significantly related to increases in depersonalization of residents, while predispositions toward provision of advice, emotional support, and socializing were significantly related to increases in sense of personal accomplishment. Sense of personal accomplishment was also positively associated with perceptions of organizational support for advising, emotional support, financial support, practical support, and socializing. Perceptions of organizational preference for emotional support were negatively associated with emotional exhaustion among caregivers.

CONCLUSIONS: Five primary conclusions are drawn from the data: (1) caregivers value providing affective over instrumental support; (2) caregivers believe they place more importance on supportive communication than their organizations; (3) role conflict is emotionally exhausting, but does not affect caregivers' self-evaluations or perceptions of residents; (4) caregivers' depersonalization of patients is related to their desire to communicate instrumental support; and (5) caregivers feel more accomplished when they believe their organization values supportive communication with patients. Organizational preference for emotional social support may improve caregivers' sense of personal accomplishment and reduce emotional exhaustion.

Jackson JL, Chamberlin J & Kroenke K. (2001). **Predictors of patient satisfaction.** *Social Sci. & Med.*, 52(4) 609-620.

Correlates of patient satisfaction at varying points in time were assessed using a survey with 2-week and 3-month follow-up in a general medicine walk-in clinic, in USA. Five hundred adults presenting with a physical symptom, seen by one of 38 participating clinicians were surveyed and the following measurements were taken into account: patient symptom characteristics, symptom-related expectations, functional status (Medical Outcomes Study Short-Form Health Survey [SF-6]), mental disorders (PRIME-MD), symptom resolution, unmet expectations, satisfaction (RAND 9-item survey), visit costs and health utilization. Physician perception of difficulty (Difficult Doctor Patient Relationship Questionnaire), and Physician Belief Scale. Immediately after the visit, 260 (52%) patients were fully satisfied with their care, increasing to 59% at 2 weeks and 63% by 3 months. Patients older than 65 and those with better functional status were more likely to be satisfied. At all time points, the presence of unmet expectations

markedly decreased satisfaction: immediately post-visit (OR: 0.14, 95% CI: 0.07-0.30), 2-week (OR: 0.07, 95% CI: 0.04-0.13) and 3-month (OR: 0.05, 95% CI: 0.03-0.09). Other independent variables predicting immediate after visit satisfaction included receiving an explanation of the likely cause as well as expected duration of the presenting symptom. At 2 weeks and 3 months, experiencing symptomatic improvement increased satisfaction while additional visits (actual or anticipated) for the same symptom decreased satisfaction. A lack of unmet expectations was a powerful predictor of satisfaction at all time-points. Immediately post-visit, other predictors of satisfaction reflected aspects of patient doctor communication (receiving an explanation of the symptom cause, likely duration, lack of unmet expectations), while 2-week and 3-month satisfaction reflected aspects of symptom outcome (symptom resolution, need for repeat visits, functional status). Patient satisfaction surveys need to carefully consider the sampling time frame as well as adjust for pertinent patient characteristics.

Jun M, Peterson R, et al. (1998). **The identification and measurement of quality dimensions in health care: focus group interview results.** *Health Care Manage Rev*, 23(4): 81-96.

**OBJECTIVE:** To examine patient, physician, and hospital administrator perceptions of quality in health care.

**SETTING:** A mid-sized, public hospital in the southwestern US.

**INTERVENTION:** Focus groups.

**DESIGN:** Qualitative.

**SUBJECTS:** Three focus groups were used. The hospital administrator group was composed of six middle-level managers at the hospital with an age range of 25 to 50 years. Four of the members were men and 2 were women. The patient focus group had 6 members of whom 5 were women. The age range was 30 to 75. Two of the women were mothers whose children were in the hospital, and 4 of the patients were employed by the hospital. The physician group was composed of 4 resident physicians who worked at the family practice facility at a hospital annex. The age range was from 30 to 45, and 3 of the members were male.

**MEASURES:** Focus groups were conducted using the "Grounded Theory" procedural method. The interviews were recorded, transcribed, and coded.

**RESULTS:** Eleven attributes of health care quality emerged from the 3 focus groups: 1) tangibles, such as appearance, processes, and cleanliness; 2) courtesy, which involved attitude, privacy, and professionalism; 3) reliability; 4) communication and interaction, in which technical complexity is explained and time is spent with the patient; 5) competence, which involved education, expected and continual improvement; 6) understanding the customer; 7) access; 8) responsiveness; 9) caring; 10) patient outcomes; and 11) collaboration. Three key differences emerged between the groups. The patient and administrator group found functional quality to be more important than did physicians. Functional quality concerns tangibles, courtesy, communication, understanding the patient, access, responsiveness, caring and collaboration. The physicians put greater emphasis on technical quality such as competence and patient outcomes. Thirdly, in the area of patients and administrators, patients focused more on courtesy, communication, and responsiveness while administrators looked at competence, understanding the customer, and collaboration.

**CONCLUSIONS:** Enhanced communication and involving patients more in their treatment emerged out of this study as areas that require more attention. Greater focus on the functional dimensions of quality would help increase perceived quality.

Kahn MW. (2008). **Etiquette-based medicine.** *New England Journal of Medicine*, 358(19): 1988-1989.

This editorial advocates training for an "etiquette-based" approach to patient care that would complement efforts to train clinicians to be more humane and the development of checklists of clinician etiquette for the clinician-patient encounter which might include: (1) asking permission to enter the room and waiting for an answer; (2) introducing yourself; (3) shaking hands (wear gloves if needed); (4) sitting down and smiling if appropriate; (5) explaining your role on the team; and (6) asking the patient how he or she is feeling about being in hospital.



Keating NL, Green DC, Kao AC, Gazmararian JA, Wu VY & Cleary PD. (2002). **How are patients' specific ambulatory care experiences related to trust, satisfaction, and considering changing physicians?** *Journal of General Internal Medicine*, 17: 29-39.

Telephone survey of 2000+ patients of a large national health insurer (58% response rate) to assess relationships between outpatient problem experiences and patients' trust in their physicians, and consideration of changing physicians. Classified as problem experiences if the patient reported that the physician did not 1) give them enough time to explain the reason for their visit 2) give answers to questions that were understandable 3) take enough time to answer questions 4) ask about how their family or living situation affects their health 5) give as much medical information as they want 5) involve them in decisions as much as they want.  
Conclusions: Problem experiences in ambulatory settings strongly related to lowered trust.

Keller VF & Baker L. (1998). **C.A.R.E. Treating patients with C.A.R.E.: participant handbook.** Copyright © 1998 by the Institute for Healthcare Communication, Inc.

Keller VF & Carroll JG. (1994). **A new model for physician-patient communication.** *Patient Education & Counseling*, 23:131-140.

The E4 model for physician-patient communication is presented with specific techniques for implementing the model. Derived from an extensive review of the literature on physician-patient communication, the model has proved to be a useful tool in workshops for and coaching of physicians regardless of specialty, experience or practice setting.

Keller VF & White MK. (1997). **Choices and Changes: a new model for influencing patient health behavior.** *Journal of Clinical Outcomes Management, Special Publication*, 17-20.

This article described the development of a model to guide clinicians in application of research-based principles of motivation and behavior change within the context of the clinician-patient encounters. The model presents a synthesis of the research evidence and specifies two core dimensions of motivation: conviction and confidence. Conviction refers to the values and beliefs that underlie a patient's readiness and intention to take action, while confidence is a reflection of self-efficacy. The model also identifies three components of effective intervention: assessment, rapport building and tailoring.

Kemp EC, Floyd MR, McCord-Duncan E, & Lang F. (2008). **Patients prefer the method of "tell back-collaborative inquiry" to assess understanding of medical information.** *J Am Board Fam Med*. 2008; 21(1):24-30.

**PURPOSE:** The goal of this study was to determine which approach to assessing understanding of medical information patients most prefer and perceive to be most effective.

**METHODS:** Two videos were shown to participants: (1) a physician explaining a medical condition and its treatment and (2) a physician inquiring about patient understanding of the medical information the patient had been given using 3 different types of inquiry: Yes-No, Tell Back-Collaborative, and Tell Back-Directive.

**RESULTS:** The Tell Back-Collaborative inquiry was significantly preferred over the other 2 approaches.

**CONCLUSIONS:** Patients strongly prefer the Tell Back-Collaborative inquiry when assessing their understanding. We recommend that physicians ask patients to restate what they understand using their own words and that they use a patient-centered approach.

Kenagy JW, Berwick DM, & Shore MF. (1999). **Service quality in health care.** *Journal of the American Medical Association*, 281 (7): 661-665.

Although US health care is described as "the world's largest service industry," the quality of service—that is, the characteristics that shape the experience of care beyond technical competence—is rarely discussed in the medical literature. This article illustrates service quality principles by analyzing a routine encounter in health care from a service quality point of view. This illustration and a review of related literature from both inside and outside health care has



led to the following 2 premises: First, if high quality service had a greater presence in our practices and institutions, it would improve clinical outcomes and patient and physician satisfaction while reducing costs, and it would create competitive advantage for those who are expert in its application. Second, many other industries in the service sector have taken service quality to a high level, their techniques are readily transferable to health care, and physicians caring for patients can learn from them.

Kerfoot KM. (2008). **Hospital and service: leading real change.** *Nursing Economics*, (26): 191-193.

A patient's decision to recommend a health care organization and the patient's loyalty scores are largely determined by the interaction patients and their families have had with the nurses. Hospitality is now the delivery of that product makes the person feel and is a dialogue that requires the server to be "on the guest's side" throughout the experience. The challenge for health care is to help our patients and their families transcend the usual routine care of our health care world and to experience an emotional connection that provides that sense of affiliation and emotional kinship with the organization and the staff. Moving from the service mindset in health care to the hospitality mindset that engages people positively and emotionally is what healing is all about.

Kettunen T, Poskiparta M, et al. (2000). **Communicator styles of hospital patients during nurse-patient counseling.** *Patient Education & Counseling*, 41(2): 161-180.

This article describes nurse-patient communication during counseling sessions. It focuses on the patient as a participant in a discussion and aims at a description of patients' communicator styles, which were observed on videotape based on 38 counseling sessions transcribed word by word. Interviews of the participating nurses and patients were used for partial support of the interpretations. The analytic method chosen was typology, used for achieving a multifaceted qualitative description of patient communication. The research material yielded 7 types of communicator styles: Quietly Assenting, Emotionally Expressive, Storyteller, Stoic Observer, Inquisitive of Detail, Dominant, and Critical Self-observer. The communicator styles were indicative of the multitude of ways in which patients participate in counseling discussions; use of the typology of styles makes it possible to describe the varying expressions of patient communication. This article presents new background information on patient communication. The outcome may prove to be useful for developing health counseling.

OBJECTIVE: To examine and describe patient communication styles.

SETTING: Finnish hospital

SUBJECTS: Nurses (n=19), patients (n=38)

DATA COLLECTION: Nurses videotaped 38 patient counseling sessions, which lasted 5 to 45 minutes, and involved topics such as discharge planning, education about an illness, admittance interviews, and other topics. Videotaped sessions were transcribed. Nurses and patients were interviewed.

DATA ANALYSIS: The typological analysis involved 8 stages: transcription, viewing tapes & reading transcripts, isolating central themes for each tape (showing initiative, self-disclosing, asking, etc.), describing how themes were manifested in verbal communication behaviors, seeking differences and comparing patients' speech & reading background literature on communication styles, defining type dimensions & grouping patients, constructing communicator style types, and relating the type descriptions to the literature on communication.

FINDINGS: Seven patient communicator types were identified: quietly assenting, emotionally expressive, storyteller, stoic observer, inquisitive of detail, dominant, and critical self-observer.

Communication behaviors for each type were described for the following features of communication: nonverbal, speech, manner of participation, topics, feedback, assertiveness, and contributing to the discussion. For quietly assenting patients (n=14), the norms for the discussion depended largely upon the practices of the hospital and the actions of the nurse. These patients are quiet and respond to nurses' questions, without bringing up other topics or expanding much on their answers. Emotionally expressive patients (7 women) discuss their feelings, talk for long periods of time, take initiative in making comments and expressing

opinions, and seem to want to create a relationship with the nurse. Storytellers (5 men) used anecdotes and humor to discuss past experiences, and replied to nurses' questions in depth. Stoic observers (n=4) expressed themselves little and showed few emotions. Sometimes, the patients gave short responses despite long pauses between nurse's questions. At other times, patients who were giving longer responses or asking questions were interrupted or ignored by the nurse and then gave only short responses thereafter. Three patients were classified as inquisitive of detail. These patients were highly attentive and asked the nurse more questions than the nurse asked them. Dominant patients (n=3) were assertive, self-assured, and often critical or corrective of the nurses' comments. These patients also sidetracked the conversation into a peripheral topic and often controlled the conversation by using "I" statements and making their own judgments, predictions, and decisions. Critical self-observers (2 women) controlled the conversation by assessing their own actions critically, and by displaying their knowledge, skills, attitudes and behaviors regarding the health topic. They also discussed the pragmatic issues involved in carrying out health behavior instructions.

**CONCLUSIONS:** Nurses in the study showed a strong tendency to direct the conversation in a routine, scripted manner and to restrict the speech of the patient. Many nurses gave patients the opportunity to ask questions only at the end of the counseling session, at which point some patients were discouraged from speaking and many patients were unable to participate fully in the health education experience. Familiarity with patient communicator styles is helpful for nurses and other health care providers for providing adequate, participatory health counseling and for understanding how to respond to patient concerns.

Kravitz RL.(2001). **Measuring patients' expectations and requests.** *Annals Internal Medicine*, 134(9 Pt 2) 881-888.

Patients seeking help for symptoms frequently worry about the underlying causes of their symptoms; have specific expectations for care; and request (or demand) time, information, and services. Understanding patients' concerns, expectations, and requests is important for clinicians, health care policymakers, and researchers. One obstacle to progress in this area has been disagreement over the most appropriate methods for identifying, monitoring, and classifying these phenomena. This article reviews the conceptual relationships linking patients' expectations, requests, and satisfaction with care; surveys contemporary approaches to the measurement of expectations and requests; and highlights recent empirical findings. The literature reviewed supports the conclusion that patients' expectations are wide ranging, can be measured, and have potentially important clinical consequences. For clinicians and policymakers alike, learning to elicit, evaluate, and understand patients' expectations will be a major task for the early part of the new century.

Langewitz W, Denz M, Keller A, et al. (2002). **Spontaneous talking time at start of consultation in outpatient clinic: cohort study.** *British Medical Journal*. 325:682-683.

Examined how long it would take outpatients at a tertiary referral centre to indicate they had completed their story if uninterrupted by their doctors. A sequential cohort of patients from the outpatient clinic of a university hospital participated (n=406; mean age 42.9 yrs). Doctors surreptitiously activated a stop watch at the start of the communication, and pressed it again when the patient indicated they wanted the doctor to take the lead. Mean spontaneous talking time was 92 seconds, and 78% of patients had finished their initial statement in 2 minutes. Seven patients talked for longer than 5 minutes. In all cases doctors felt that the patients were giving important information and should not be interrupted. Implications for patient treatment and doctor-patient communication are discussed.

Larson EB & Yao X. (2005). **Clinical empathy as emotional labor in the patient-physician relationship.** *Journal of American Medical Association*, 293(9), 100-1106.

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (ie, management of experienced and displayed emotions to present a certain image). Since the publication of

Hochschild's *The Managed Heart* in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (ie, generating empathy-consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the method-acting tradition used by some stage and screen actors), surface acting (ie, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians first to recognize that their work has an element of emotional labor and, second, to consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly fragmented and technological world of modern medicine.

Leland J. (2008). In 'sweetie' and 'dear,' a hurt for the elderly. *New York Times*, October 7, 2008.

Levinson W, Gorawara-Bhat R & Lamb J. (2000). **A study of patient clues and physician responses in primary care and surgical settings.** *JAMA: The Journal of the American Medical Association*, 284(8) 1021-1027.

**OBJECTIVE:** To explore the nature and frequency of patient clues during medical encounter and physician response among primary care physicians and surgeons.

**DESIGN:** Descriptive study of audio-taped office visits (data set was part of a larger research project that examined the relationship between physician-patient communication and medical malpractice).

**SETTING:** Community-based practices of primary care physicians and surgeons in Oregon and Colorado.

**SUBJECTS:** 116 randomly selected routine office visits to 54 primary care physicians and 62 surgeons (94% male, 91% Caucasian, 67% group practice). Ten patients per physician were selected sequentially from the waiting rooms (54% female, 88% Caucasian, 71% married, average age=54).

**INTERVENTION:** None.

**MEASURES:** Audio-taped interactions and transcripts were reviewed to identify and describe segments of the interview in which there were clues about patients' emotional or social concerns. Clues that were initiated by the patient were coded for type and timing and nature of physician response. In addition, physician questions that encouraged patient to discuss a personal topic were also coded as physician-initiated clues. Length of visit was also recorded.

**RESULTS:** Clues occurred in 52% of the primary care visits (mean number of clues =2.6) and in 53% of the surgical visits (mean number of clues = 1.9). Patients initiated approximately 70% of those clues and physicians initiated approximately 30%. Of the patient led clues in primary care visits, 76% were emotional and 60% in the surgical setting. Physicians missed the opportunity to respond to patient led clues 79% of the time in primary care and 62% in the surgical setting. In 50% of those interviews where the physician missed the opportunity to respond to the patient-led clue, the patient brought up the same issue (clue) a second or third time. In addition, in primary care, visits were longer when there was a missed opportunity to respond by the physician compared with visits where the physician responded with a positive response (mean time, 20.1 min vs. 17.6 min).

**CONCLUSIONS/RECOMMENDATIONS:** Patients offer clues to physicians that provide rich opportunities for empathy and a greater understanding of patients' lives. In primary care and surgery settings, physicians tend to miss these clues and thus overlooking opportunities to strengthen the doctor-patient relationship. Two aspects of the medical encounter uncovered in this study, patient clues and physician responses, should be recognized as being interdependent

and necessary in building a trusting relationship between physician and patients and impacting health outcome.

Levinson W, Kao A, Kuby A, & Thisted R. (2005). **Not all patients want to participate in decision making: a national study of public preferences.** *Journal of General Internal Medicine*, 20(6):531-535.

**BACKGROUND:** The Institute of Medicine calls for physicians to engage patients in making clinical decisions, but not every patient may want the same level of participation.

**OBJECTIVES:** 1) To assess public preferences for participation in decision making in a representative sample of the U.S. population. 2) To understand how demographic variables and health status influence people's preferences for participation in decision making.

**DESIGN AND PARTICIPANTS:** A population-based survey of a fully representative sample of English-speaking adults was conducted in concert with the 2002 General Social Survey (N= 2,765). Respondents expressed preferences ranging from patient-directed to physician-directed styles on each of 3 aspects of decision making (seeking information, discussing options, making the final decision). Logistic regression was used to assess the relationships of demographic variables and health status to preferences.

**MAIN RESULTS:** Nearly all respondents (96%) preferred to be offered choices and to be asked their opinions. In contrast, half of the respondents (52%) preferred to leave final decisions to their physicians and 44% preferred to rely on physicians for medical knowledge rather than seeking out information themselves. Women, more educated, and healthier people were more likely to prefer an active role in decision making. African-American and Hispanic respondents were more likely to prefer that physicians make the decisions. Preferences for an active role increased with age up to 45 years, but then declined.

**CONCLUSION:** This population-based study demonstrates that people vary substantially in their preferences for participation in decision making. Physicians and health care organizations should not assume that patients wish to participate in clinical decision making, but must assess individual patient preferences and tailor care accordingly.

† Lin MY, Kressin NR. (2015). **Race/ethnicity and Americans' experiences with treatment decision making.** *Patient Educ Couns*, pii: S0738-3991(15)30025-2. doi: 10.1016/j.pec.2015.07.017.

**OBJECTIVE:** Despite widespread documentation of racial/ethnic disparities in medical care, population-wide variation in Americans' experiences with care are not well understood. We examined whether race/ethnicity is associated with information received from physicians regarding treatment recommendations.

**METHODS:** We conducted a secondary analysis of cross-sectional survey data from a nationally representative sample (N=1238). We assessed patients' personal experiences of receiving information about the rationale for treatment recommendations from their physicians.

**RESULTS:** Overall, respondents of minority race/ethnicity received less information from their doctors about the rationale for treatment recommendations. After adjustment for possible confounders, doctors talked less often with patients of 'other' race/ethnicity about reasons for treatment recommendations. Both Blacks' and Hispanics' doctors less often cited their own experiences, or scientific research as a reason for treatment recommendations.

**CONCLUSION:** Americans' experiences with information communicated by physicians regarding treatment rationale varies significantly on some dimensions by race/ethnicity, suggesting that differences in key elements of shared decision making are evident in the care of racial/ethnic minorities.

**PRACTICE IMPLICATIONS:** Physicians should evaluate the extent to which their communication with patients varies by patient race/ethnicity, and make efforts to ensure that they share equally with all patients regarding the rationale for treatment recommendations.



Lovgren G, Sandman PO, et al. (1998). **The view of caring among patients and personnel.** *Scandinavian Journal of Caring Sciences*, 12(1): 33-42.

Examines the level of satisfaction with the quality of care of patients in hospital and primary health care in Västerbotten, Sweden. Use of questionnaire concerning the relationship and task aspects of care; Group with the highest and lowest level degree of satisfaction; Interpretation of health personnel on patient satisfaction. All patients in hospital care and primary health care in the county of Västerbotten, Sweden (n=5158) were asked to express their level of satisfaction with the quality of care. The study was carried out on one specific day. All personnel on duty that day (n=2824) were also included and asked to give their interpretations of their patients' experiences. A questionnaire containing positive and negative statements concerning both the relationship and the task aspects of care was used. The results showed that the youngest and oldest patients expressed the highest degree of satisfaction; while young and middle - aged patients expressed a more restrained view. The least satisfactory aspects concerned the opportunities to express criticism and the possibilities of receiving information about access to help outside the health care organization. The personnel's responses agreed with those of the patients, but fewer personnel thought that their patients were satisfied than was in fact the case. DESIGN: cross-sectional, descriptive survey.

SUBJECTS: All patients in hospital care and primary health care in the county of Västerbotten, Sweden (n=5158; 3950 (77%) responded) and all personnel on duty (n=2824; 2632 (84%) responded) on a specific day.

DATA COLLECTION: A 35-item survey asked patients to rate their satisfaction with their health care experience and asked caregivers to rate their perception of patients' satisfaction. A 6-point agreement scale was used (always, very often, quite often, quite seldom, very seldom, never, not applicable).

DATA ANALYSIS: Factor analysis was used to identify four factors that explained 64% of the variance in survey responses. The variables with the highest factor loading for each variable were used to calculate associations between the factors and patient/staff background variables.

FINDINGS: The four factors which explained patient satisfaction were: 1) satisfactory relationship in care, 2) satisfaction with the way basic needs are met, 3) unsatisfactory relationship in care, and 4) satisfactory information concerning care after discharge. The variables with the highest factor loading for each factor were: the personnel understand when I talk about my problems (1), the personnel respond to me in a loving way (1), I receive adequate help with hygiene (2), the personnel treat me in a nonchalant way (3), and I receive adequate information about access to help outside the health care organization (4).

CONCLUSIONS: Patients were least satisfied with their opportunities to express criticism with care or to receive information about access to care outside the health care organization. The oldest and youngest patients, and men, ranked their care experience higher, but patient satisfaction was high overall. Staff underestimated patients' satisfaction, especially regarding whether they were treated lovingly, understood, and were able to express criticism.

Lown BA, Roy E, Gorman P, Sasson JP. (2009). **Women's and residents' experiences of communication in the diagnostic mammography suite.** *Patient Education and Counseling*. 77 (3): 328-337.

To gain understanding of radiology residents' and women's experiences, concerns, information needs, coping strategies and perspectives about optimal communication during diagnostic mammography. Methods: Qualitative analysis of focus groups of radiology residents and women who had undergone diagnostic mammograms. Results: Five categories of themes emerged from our analysis: information needs, perspectives and ideals, emotional experiences and observations, working together, individual experiences, and others' roles. Women preferred continuous orientation, clear explanations and emotional support by physicians and radiology technologists throughout diagnostic processes. Communication about diagnostic mammogram results evoked the threat of breast cancer and was experienced as "bad news" by women, but not necessarily by all radiology residents. Lack of collaboration among radiologists, technologists and other healthcare professionals engendered confusion and anxiety in patients.



Radiology residents felt inadequately prepared to meet the communication challenges of providing information and emotional support tailored to women's needs in this context. Conclusion: Women's experiences are influenced by the extent to which they receive clear information and support, and perceive collaboration among professionals involved in the diagnostic mammography process. Practice implications: Radiology education must address communication with patients and among healthcare professionals involved in the care of patients undergoing diagnostic procedures and interventions.

† Lown BA, Rosen J, Marttila J. (2011). **An Agenda For Improving Compassionate Care: A Survey Shows About Half Of Patients Say Such Care Is Missing.** *Health Aff*, 30(9):1772-8.

As the US health care system undergoes restructuring and pressure to reduce costs intensifies, patients worry that they will receive less compassionate care. So do health care providers. Our survey of 800 recently hospitalized patients and 510 physicians found broad agreement that compassionate care is "very important" to successful medical treatment. However, only 53 percent of patients and 58 percent of physicians said that the health care system generally provides compassionate care. Given strong evidence that such care improves health outcomes and patients' care experiences, we recommend that national quality standards include measures of compassionate care; that such care be a priority for comparative effectiveness research to determine which aspects have the most influence on patients' care experiences, health outcomes, and perceptions of health-related quality of life; and that payers reward the provision of such care. We also recommend the development of systematic approaches to help health care professionals improve the skills required for compassionate care.

Lutfey KE, & Ketcham JD. (2005). **Patient and provider assessments of adherence and the sources of disparities: evidence from diabetes care.** *Health Services Research*, 40(6), 1803-1817.

OBJECTIVE: To (1) compare diabetes patients' self-assessments of adherence with their providers' assessments; (2) determine whether there are systematic differences between the two for certain types of patients; and (3) consider how the cognitive processing that providers use to assess adherence might explain these differences.

DATA SOURCES/STUDY SETTING: Primary survey data were collected in 1998 from 156 patient provider pairs in two subspecialty endocrinology clinics in a large Midwestern city.

STUDY DESIGN: Data were collected in a cross-sectional survey study. Providers were surveyed immediately after seeing each diabetes patient, and patients were surveyed via telephone within 1 week of clinic visits.

DATA COLLECTION/EXTRACTION METHODS: Bivariate descriptive results and multivariate regression analyses are used to examine how patient characteristics relate to four measures of overall adherence assessments: (1) patients' self-assessments; (2) providers' assessments of patient adherence; (3) differences between those assessments; and (4) absolute values of those differences.

PRINCIPLE FINDINGS: Patient self-assessments are almost entirely independent of observable characteristics such as sex, race, and age. Provider assessments vary with observable characteristics such as patient race and age but not with less readily observable factors such as education and income. For black patients, we observe that relative to white patients, providers' assessments are significantly farther away from-although not systematically farther above or below-patients' self-assessments.

CONCLUSIONS: Providers appear to rely on observable cues, particularly age and race, to make inferences about an individual patient's adherence. These findings point to a need for further research of various types of provider cognitive processing, particularly in terms of distinguishing between prejudice and uncertainty. If disparities in assessment stem more from information and communication problems than from provider prejudice, policy interventions should facilitate providers' systematic acquisition and processing of information, particularly for some types of patients.

Maisels M, Jeffrey MB, & Kring EA. (2005). **A simple approach to improving patient satisfaction.** *Clinical Pediatrics*. 44(9):797-800.

Improved communication with families may significantly increase their satisfaction with the care of their hospitalized child. The families of children admitted to a general pediatric service were randomly assigned to receive a daily visit from a communicator/facilitator whose purpose was to respond to any questions the family might have and, if necessary, to explain results of laboratory tests. Control families received routine care. At the time of discharge (study 1) or following discharge (study 2), the families were asked to complete a brief questionnaire regarding the quality of nursing care and physician care (both attending and resident physician). Responses were received from 76/83 (91.6%) in the study group and 75/83 (90.4%) in the control group. There was a highly significant improvement in parent satisfaction with all of the care delivered—nursing, attending physician, and resident care ( $p \leq .005$  in all categories of care). The simple act of offering a sympathetic and understanding ear, and answering questions, many of which were unrelated to the medical problem at hand, had a salutary effect on overall patient and family satisfaction with both nursing and medical care. In the current era of intense competition to fill available beds and the important emphasis on quality of care, this approach deserves further evaluation by department managers and hospital administrators.

Makoul G. (2001). **Essential elements of communication in medical encounters: the Kalamazoo consensus statement.** *Academic Medicine: Journal of the Association of American Medical Colleges*, 76(4):390-393.

In May 1999, 21 leaders and representatives from major medical education and professional organizations attended an invitational conference jointly sponsored by the Institute for Healthcare Communication and the Fetzer Institute. The participants focused on delineating a coherent set of essential elements in physician-patient communication to: (1) facilitate the development, implementation, and evaluation of communication-oriented curricula in medical education and (2) inform the development of specific standards in this domain. Since the group included architects and representatives of five currently used models of doctor-patient communication, participants agreed that the goals might best be achieved through review and synthesis of the models. Presentations about the five models encompassed their research base, overarching views of the medical encounter, and current applications. All attendees participated in discussion of the models and common elements. Written proceedings generated during the conference were posted on an electronic listserv for review and comment by the entire group. A three-person writing committee synthesized suggestions, resolved questions, and posted a succession of drafts on a listserv. The current document was circulated to the entire group for final approval before it was submitted for publication. The group identified seven essential sets of communication tasks: (1) build the doctor-patient relationship; (2) open the discussion; (3) gather information; (4) understand the patient's perspective; (5) share information; (6) reach agreement on problems and plans; and (7) provide closure. These broadly supported elements provide a useful framework for communication-oriented curricula and standards.

Makoul G, Zick A & Green M. (2007). **An evidence-based perspective on greetings in medical encounters.** *Arch Intern Med*, 11;167(11):1172-6.

**BACKGROUND:** Widely used models for teaching and assessing communication skills highlight the importance of greeting patients appropriately, but there is little evidence regarding what constitutes an appropriate greeting.

**METHODS:** To obtain data on patient expectations for greetings, we asked closed-ended questions about preferences for shaking hands, use of patient names, and use of physician names in a computer-assisted telephone survey of adults in the 48 contiguous United States. We also analyzed an existing sample of 123 videotaped new patient visits to characterize patterns of greeting behavior in everyday clinical practice.

**RESULTS:** Most (78.1%) of the 415 survey respondents reported that they want the physician to shake their hand, 50.4% want their first name to be used when physicians greet them, and 56.4% want physicians to introduce themselves using their first and last names; these

expectations vary somewhat with patient sex, age, and race. Videotapes revealed that physicians and patients shook hands in 82.9% of visits. In 50.4% of the initial encounters, physicians did not mention the patient's name at all. Physicians tended to use their first and last names when introducing themselves.

**CONCLUSIONS:** Physicians should be encouraged to shake hands with patients but remain sensitive to nonverbal cues that might indicate whether patients are open to this behavior. Given the diversity of opinion regarding the use of names, coupled with national patient safety recommendations concerning patient identification, we suggest that physicians initially use patients' first and last names and introduce themselves using their own first and last names.

† Massey M, Roter D. (2015). **Assessment of immigrant certified nursing assistants' communication when responding to standardized care challenges.** *Patient Educ Couns*, pii: S0738-3991(15)30048-3. doi: 10.1016/j.pec.2015.08.010.

**OBJECTIVE:** Certified nursing assistants (CNAs) provide 80% of the hands-on care in US nursing homes; a significant portion of this work is performed by immigrants with limited English fluency. This study is designed to assess immigrant CNA's communication behavior in response to a series of virtual simulated care challenges.

**METHODS:** A convenience sample of 31 immigrant CNAs verbally responded to 9 care challenges embedded in an interactive computer platform. The responses were coded with the Roter Interaction Analysis System (RIAS), CNA instructors rated response quality and spoken English was rated.

**RESULTS:** CNA communication behaviors varied across care challenges and a broad repertoire of communication was used; 69 of response content was characterized as psychosocial. Communication elements (both instrumental and psychosocial) were significant predictors of response quality for 5 of 9 scenarios. Overall these variables explained between 13% and 36% of the adjusted variance in quality ratings.

**CONCLUSION:** Immigrant CNAs responded to common care challenges using a variety of communication strategies despite fluency deficits.

**PRACTICE IMPLICATIONS:** simulation-based observation is a feasible, acceptable and low cost method of communication assessment with implications for supervision, training and evaluation of a para-professional workforce.

† Mauksch LB, Dugdale DC, Dodson S & Epstein R. (2008). **Relationship, communication, and efficiency in the medical encounter: creating a clinical model from a literature review.** *Arch Intern Med.*, 168(13):1387-1395

**BACKGROUND:** While there is consensus about the value of communication skills, many physicians complain that there is not enough time to use these skills. Little is known about how to combine effective relationship development and communication skills with time management to maximize efficiency. Our objective was to examine what physician-patient relationship and communication skills enhance efficiency.

**DATA SOURCES:** We conducted searches of PubMed, EMBASE, and PsychINFO for the date range January 1973 to October 2006. We reviewed the reference lists of identified publications and the bibliographies of experts in physician-patient communication for additional publications.

**STUDY SELECTION:** From our initial group of citations (n=1146), we included only studies written in English that reported original data on the use of communication or relationship skills and their effect on time use or visit length. Study inclusion was determined by independent review by 2 authors (L.B.M. and D.C.D.). This yielded 9 publications for our analysis.

**DATA EXTRACTION:** The 2 reviewers independently read and classified the 9 publications and cataloged them by type of study, results, and limitations. Differences were resolved by consensus.

**RESULTS:** Three domains emerged that may enhance communication efficiency: rapport building, up-front agenda setting, and acknowledging social or emotional clues

**CONCLUSIONS:** Building on these findings, we offer a model blending the quality-enhancing and time management features of selected communication and relationship skills. There is a need for additional research about communication skills that enhance quality and efficiency.

† Mazzi AM, Rimondini M, Boerma WGW, Zimmerman C, Bensing JM. (2015). **How patients would like to improve medical consultations: insights from a multicultural European study.** *Patient Educ Couns*, pii: S0738-3991(15)30047-1. doi: 10.1016/j.pec.2015.08.009.

**OBJECTIVE:** In a previous qualitative study (GULiVer-I), a series of lay-people derived recommendations ('tips') was listed for doctor and patient on 'How to make medical consultation more effective from the patient's perspective'. This work (GULiVer-II) aims to find evidence whether these tips can be generally applied, by using a quantitative approach, which is grounded in the previous qualitative study.

**METHODS:** The study design is based on a sequential mixed method approach. 798 patients, representing United Kingdom, Italy, Belgium and the Netherlands, were invited to assess on four point Likert scales the importance of the GULiVer-I tips listed in the 'Patient Consultation Values questionnaire'.

**RESULTS:** All tips for the doctor and the patient were considered as (very) important by the majority of the participants. Doctors' and patients' contributions to communicate honestly, treatment and time management were considered as equally important (65, 71 and 58% respectively); whereas the contribution of doctors to the course and content of the consultation was seen as more important than that of patients.

**CONCLUSIONS:** The relevance of GULiVer-I tips is confirmed, but tips for doctors were assessed as more important than those for patients.

**PRACTICE IMPLICATIONS:**

Doctors and patients should pay attention to these "tips" in order to have an effective medical consultation.

† Montague E, Chen P, Xu J, Chewning B & Barrett B. (2013). **Nonverbal interpersonal interactions in clinical encounters and patient perceptions of empathy.** *J Participat Med.*, 5

**OBJECTIVE:** The relationship between nonverbal behaviors and patient perceptions of clinicians has been underexplored. The aim of this study was to understand the relationship between nonverbal communication behaviors (eye contact and social touch) to patient assessments of clinician (empathy, connectedness, and liking).

**METHODS:** Hypotheses were tested including clinician and patient nonverbal behaviors (eye contact, social touch) were coded temporally in 110 videotaped clinical encounters. Patient participants completed questionnaires to measure their perception of clinician empathy, connectedness with clinician, and how much they liked their clinician.

**RESULTS:** Length of visit and eye contact between clinician and patient were positively related to the patient's assessment of the clinician's empathy. Eye contact was significantly related to patient perceptions of clinician attributes, such as connectedness and liking.

**CONCLUSION:** Eye contact and social touch were significantly related to patient perceptions of clinician empathy. Future research in this area is warranted, particular with regards to health information technology and clinical system design.

**PRACTICE IMPLICATIONS:** Clinical environments designed for patient and clinician interaction should be designed to facilitate positive nonverbal interactions such as eye contact and social touch. Specifically, health information technology should not restrict clinicians' ability to make eye contact with their patients.

Muntlin A, Gunningberg L, & Carlsson M. (2006). **Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement.** *Journal of Clinical Nursing*. 15(8):1045-1056.

**AIMS:** This paper reports a study to identify patient's perceptions of quality of care at an emergency department and areas for quality improvement.

**BACKGROUND:** Patients are not always satisfied with the care received at emergency departments. More attention needs to be paid to the specific needs and expectations of the non-urgent group of patients, who make up the majority of attenders at many emergency departments. Nurses' and physicians' perceptions about good quality of care do not always agree with patients' perceptions. Instruments measuring patient satisfaction have often been focused



on inpatient treatment.

**METHOD:** A prospective, descriptive survey design was adopted and the study took place in one emergency department at a Swedish university hospital in 2002. The participants were 99 women and 101 men, with an average age of 51 years. The emergency department version of the questionnaire Quality from the Patient's Perspective was used for data collection.

**RESULTS:** Patients estimated quality of care at the emergency department as fairly good, but there were areas in need of improvement. A high percent of inadequate quality was related to the environment in the emergency department. About 20% of patients reported that they did not receive effective pain relief. More than 20% estimated that nurses did not show an interest in their life situation and patients did not receive useful information on self-care and about which physician was responsible for their medical care.

**CONCLUSIONS:** The use of a research-based instrument gave valuable information for quality improvement in clinical practice. Many of the identified areas for quality improvement are related to nursing care. Therefore, the importance of nursing care in the emergency department should be highlighted to nurses and physicians and they also need to be more attentive to the need of the individual patient. **Relevance to clinical practice:** Identifying areas for quality improvements are important, to know where to take action. These findings may facilitate the work with changing attitudes and working routines, which are needed to deliver effective care and to improve patients' perceptions of quality of care at emergency departments.

Nerney M, Chin M, Jin L, Karrison TG, Walter J, Mulliken R, Miller A, Hayley D & Friedmann P. (2001). **Factors associated with older patients' satisfaction with care in an inner-city emergency department.** *Annals of Emergency Medicine.* 38(2):140-145.

**STUDY OBJECTIVES:** We sought to assess older patients' satisfaction with care in the emergency department and to identify factors associated with global satisfaction with care.

**METHODS:** We performed a prospective cohort study of 778 patients 65 years of age and older presenting to an urban academic ED between 1995 and 1996, of whom 79% were black and 63% were female. A baseline survey at presentation to the ED asked for demographic information, medical history, and health-related quality of life information. A follow-up satisfaction survey asked patients to rate the care they received in the ED on a 5-point Likert scale (1=excellent, 5=poor). Overall satisfaction with care, dichotomized into responses of "excellent" versus all others, was the primary dependent variable in our bivariate analyses.

**RESULTS:** Of respondents, 40% rated their ED care as "excellent." Variables significantly correlated with high satisfaction include having the perception of time spent in the ED as not "too long," having the emergency physicians and nurses clearly answer patients' questions, having a relationship of trust with an ED staff member, being told why tests were done, feeling involved in decisions about care as much as they wanted, having pain addressed fully, having a perception of greater health status, and having fewer comorbid conditions at the time of the ED visit. Results may be applicable only to urban academic EDs and may be limited by time elapsed between ED visits and follow-up surveys.

**CONCLUSION:** To improve quality of care for older adults in the ED, physicians should be more attentive to older patients' concerns and questions, recognize and aggressively treat pain, and reduce the patients' perception of a long waiting time.

O'Connor MB, Nolan DP, O'Dwyer M, O'Shea S & Phelan MJ. (2011). **Doctor-patient Introductions: getting it right.** *Irish Journal of Medical Science,* 180(4):935-936.

The first interaction a doctor has with a patient can often be the foundation on which the doctor-patient relationship blossoms or perishes. Those first few seconds in a medical encounter are pivotal in creating the rapport, making the patient feel comfortable, and setting the tone for a medical consultation. Historically, physicians and medical students are encouraged to shake hands with the patient, address the patient by name, and introduce themselves. This communication process is an important part of a medical consultation and can affect patient satisfaction. Such is the importance of this communication process that it is now recognised as a core clinical skill when practicing in a medical setting. It also needs to be highlighted that non-verbal communication is extremely important and a doctor's attire is to the fore in this area.

From this study, we can conclude that patients, from this cohort, prefer doctors to address them in a friendly personal manner with the use of only first names being very acceptable. This is in direct comparison with how patients prefer doctors to introduce and present themselves, with the use of using of title, full name and formal attire being viewed most appropriate, with the traditional handshake now less acceptable.

Osborne L. (1995). **Resolving patient complaints: a step-by-step guide to effective service recovery.** Gaithersburg, MD, Aspen Publishers, Inc.

DESCRIPTION OF CONTEXT: Provides an overview of service recovery combined with a procedural outline for accomplishing service recovery.

TOPIC/SCOPE: Discusses the importance of customer complaints and service recovery. A guideline is provided for conducting service recovery to resolution. The protocols are in-depth with examples of initial letters, follow-up letters, progress report letters, etc. being provided in the book. Examples of how to document complaints and identify trends of complaints are also given. Additionally, different patient types are described along with recommendations on the correct ways to handle service recovery with these patients. Service recovery protocols are provided for medical receptionists, physicians, patient representatives, member services departments, and for formal medical staff reviews of complaints. Complaints are broken down by subject.

CONCLUSIONS/RECOMMENDATIONS: Provides behavioral guidelines for implementing service recovery procedures within a medical setting. An in-depth and comprehensive book that is practical in its design.

Quill TE, Arnold RM & Platt F. (2001). **“I wish things were different”: expressing wishes in response to loss, futility, and unrealistic hopes.** *Annals of Internal Medicine*, 135(7) 551-555.

Physicians who care for patients encounter many powerful and painful emotions, including anger, sadness, fear, grief, loss, hopelessness, and blame. Many studies suggest that physicians should express empathy in response to emotion-laden patient statements to ensure that patients feel listened to and understood. These physician responses usually consist of efforts to comprehend how things feel to the patient and to express that understanding back to the patient. Situations that evoke loss, guilt, or hopelessness are particularly hard for physicians to respond to empathically. Physicians who think that they have failed a dying patient and who fear depriving the patient of hope may respond by avoiding the topic entirely, by overcompensating with overtreatment, or by apologizing for not “saving” the patient. When a patient expresses overwhelming anger or disappointment with limitations in medicine, physicians may be afraid that any explicit response to the patient’s emotion may be construed as evidence of their failure, mistake, or inadequacy. In these challenging situations, we have observed that many physicians attempt to respond empathically by stating “I’m sorry.” This well-intentioned response, although frequently appropriate, may be misinterpreted and misdirected. We have found that saying “I wish...(things were different)” to the patient and family is a more effective initial response. We explicate some of the challenges of saying “I’m sorry” and explore the potential benefits of joining with patients and families and saying “I wish...” in specific, difficult clinical scenarios.

Rabinowitz I, Tamir R, & Reis A. (2004). **Length of patient’s monologue, rate of completion, and relation to other components of the clinical encounter.** *British Medical Journal*, 328: 501-502.

The patient’s opening statement in a consultation (the patient’s monologue) is an important part of history taking, and doctors are encouraged not to interrupt the patient--but they often do, probably because they think that the patient’s monologue is time consuming. When uninterrupted, patients conclude their monologue in less than 30 seconds in primary care and about 90 seconds in consultant settings. The researchers assessed encounters in primary care that included a new clinical problem, recording the length and rate of completion of patients’ monologues before and after instructing doctors not to interrupt.

Rao JK, Weinberger M & Kroenke K. (2000). **Visit-specific expectations and patient-centered outcomes: a literature review.** *Archives of Family Medicine*, 9(10) 1148-1155.

**BACKGROUND:** Primary care patients often have certain expectations when visiting physicians, many of which may be undetected. These unmet expectations can affect outcomes such as satisfaction with care. We performed a formal literature review to examine the effect of fulfillment of patients' visit-specific expectations on their satisfaction as well as on health status and compliance.

**PATIENTS AND METHODS:** Included studies were conducted in primary care settings, systematically recruited patients, elicited previsit and/or postvisit expectations relative to specific visits, and measured patient-centered outcomes. Two reviewers abstracted information on study characteristics; types, timing, and method of expectation ascertainment; and outcomes. Disagreements were resolved by consensus.

**RESULTS:** Twenty-three studies were reviewed including 7 trials, 4 cohort studies, and 12 cross-sectional studies. Patients frequently expected information rather than specific physician actions, but physicians often did not accurately perceive patients' visit-specific expectations. In 19 studies that assessed post-visit patient satisfaction, a positive association between meeting patient expectations and overall satisfaction was demonstrated in 11 studies, inconclusive in 3, and not established in 5. In 2 studies assessing physician satisfaction, physicians with access to patients' expectations were more satisfied than those without access. Other outcomes (symptom or disease improvement, health status, test ordering, health care costs, psychological symptoms) were measured in only a few studies, and the results were inconclusive.

**CONCLUSIONS:** Addressing patients' visit-specific expectations appears to affect satisfaction to a modest degree. Future studies should evaluate methods that efficiently elicit, prioritize, and provide patients' previsit expectations for physicians and should examine the longitudinal effect of expectation fulfillment on patient outcomes.

Razavi D, Delvaux N, et al. (2000). **Testing health care professionals' communication skills: the usefulness of highly emotional standardized role-playing sessions with simulators.** *Psycho-Oncology*, 9(4): 293-302.

Assessed the communication skills (CS) of 25 health care professionals (HCPs) and the effectiveness of training workshops (TWs). Three emotionally different standardized role-playing session (SRPS) contexts--weakly emotional (WE-), moderately emotional (ME-), and highly emotional (HE-)—were tested to assess induced CS and sensitivity to TW-related changes. Tape-recorded SRPS, scheduled before and after the TW, were re-transcribed, and assessed according to the Cancer Research Campaign Workshop Evaluation Manual, which provides a rating of form, function and structure for each utterance. Results show that induced CS is different in WE-, ME-, and HE-SRPS. HE-SRPS induced more inappropriate CS, such as asking directing questions, providing inappropriate information and false reassurances, and making blockings. HE-SRPS also induce forms, functions, and levels of utterances which are more sensitive to TW effects: increase of open questions, of clarification and checking, and decrease of the providing of inappropriate advice and of 'blocking' utterances. From these findings, the authors conclude that SRPS with HE content should be recommended for the assessment of TW effectiveness.

**OBJECTIVE:** To assess the impact of training workshops on the communication skills of health care professionals, as portrayed during standardized role-playing sessions.

**SETTING:** training workshop for health care professionals in Brussels, Belgium.

**SUBJECTS:** Health care professionals (n=25); 72% nurses.

**DESIGN:** Pre-test/ Post-test.

**INTERVENTION:** A psychosocial skills training workshop was conducted for 6-hours/ day during 18 days over a 20-week period (108 hours). 50% consisted of role-playing and 50% was education regarding psychological and psychiatric dimensions of cancer diagnosis & progression, patients' and relatives' coping mechanisms, loss and bereavement, psychological interventions, and other related issues. Female actors were trained to role-play a patient in scripted scenarios in which the emotional content was weakly, moderately, or highly emotional.

Health care professionals role-played with the actors. Each health care professional role-played each of the 3 scenarios before and after the training workshop. Role-playing sessions lasted 20 minutes each.

**DATA COLLECTION:** Standardized role-playing sessions were audio-recorded, transcribed, and segmented into utterances. Trained, independent psychologists for communication skills rated utterances: form, function, content, pertinence, emotional level, cue base, blockings, and control. Form could include question (open-ended, directed, multiple), assertion, and other categories. Functions could include empathy, reassurance, information provision, false reassurance, etc. Relevance evaluated the consistency of the message content. Emotional depth level measured the intensity of feelings expressed or mentioned. Blocking reactions referred to health care professionals' avoidance of discussing patients' intense or depressive feelings. Control measured which person was leading the interview. Inter-rater agreement for each category ranged from 73% to 91%.

**DATA ANALYSIS:** Communication skill category frequencies were calculated for each role-playing session. Multivariate analyses of variance and Friedman's non-parametric tests were used to compare mean frequency values of communication skill categories. Pre-test/ Post-test change was assessed using paired Student's t tests and a 2 (time) X 3 (emotion level) MANOVA.

**FINDINGS:** At baseline, weakly emotional sessions had more incomplete utterances, more appropriate information provision, and less blocking. Moderately emotional sessions contained more statements, acknowledgement, empathy, negotiating, summarizing, and reassurances. Highly emotional sessions contained more leading, directing, multiple questions, eliciting of information, clarification, inappropriate information-provision, false reassurances, and blocking behaviors. After the training workshops, the behaviors in the highly emotional sessions were most likely to change in the categories of form, function, and emotional level (and weakly emotional sessions were least likely to change). In highly emotional sessions, open-ended, partially open-ended, and screening questions increased, eliciting information and clarification increased, inappropriate information-provision decreased, and blocking decreased.

**CONCLUSIONS:** In general, health care professionals were more likely to use inappropriate communication skills during highly emotional role-playing sessions, but positive behaviors increased and negative behaviors decreased after training.

Rhodes KV, Vieth T, He T, Miller A, Howes DS, Bailey O, Walter J, Frankel R & Levinson W. (2004). **Resuscitating the physician-patient relationship: emergency department communication in an academic medical center.** *Annals of Emergency Medicine.* 44(3):262-267.

**STUDY OBJECTIVE:** We characterize communication in an urban, academic medical center emergency department (ED) with regard to the timing and nature of the medical history survey and physical examination and discharge instructions.

**METHODS:** Audiotaping and coding of 93 ED encounters (62 medical history surveys and physical examinations, 31 discharges) with a convenience sample of 24 emergency medicine residents, 8 nurses, and 93 nonemergency adult patients.

**RESULTS:** Patients were 68% women and 84% black, with a mean age of 45 years. Emergency medicine providers were 70% men and 80% white. Of 62 medical history surveys and physical examinations, time spent on the introduction and medical history survey and physical examination averaged 7 minutes 31 seconds (range 1 to 20 minutes). Emergency medicine residents introduced themselves in only two thirds of encounters, rarely (8%) indicating their training status. Despite physician tendency (63%) to start with an open-ended question, only 20% of patients completed their presenting complaint without interruption. Average time to interruption (usually a closed question) was 12 seconds. Discharge instructions averaged 76 seconds (range 7 to 202 seconds). Information on diagnosis, expected course of illness, self-care, use of medications, time-specified follow-up, and symptoms that should prompt return to the ED were each discussed less than 65% of the time. Only 16% of patients were asked whether they had questions, and there were no instances in which the provider confirmed patient understanding of the information.

**CONCLUSION:** Academic EDs present unique challenges to effective communication. In our study, the physician-patient encounter was brief and lacking in important health information.



Provision of patient-centered care in academic EDs will require more provider education and significant system support.

Rice B. (2005). **Ten ways to guarantee a lawsuit.** *Medical Economics*. Retrieved on November 16, 2005, from <http://www.memag.com/memag/article/articleDetail.jsp?id=168737>

This article provides a set of guidelines for clinicians to address the malpractice crisis. The author reminds the reader that the majority of patients who suffer an injury as a result of medical negligence do not end up suing their doctors. Instead, patients that decide to sue their physician are motivated by the nonclinical aspects of the problem, which they view as ineffective communication and subsequent problematic relationships with their physician. The author based the information in the article following interviews with malpractice attorneys—those who work for plaintiffs as well as for doctors—and risk management consultants to come up with a list of guidelines and actions for clinicians to avoid patient complaints and malpractice risk.

† Riess H & Kraft-Todd G. (2014). **E.M.P.A.T.H.Y.: a tool to enhance nonverbal communication between clinicians and their patients.** *Academic Medicine*, 89(8): 1108-12

There is a gap in the medical education literature on teaching nonverbal detection and expression of empathy. Many articles do not address nonverbal interactions, instead focusing on “what to say” rather than “how to be.” This focus on verbal communication overlooks the essential role nonverbal signals play in the communication of emotions, which has significant effects on patient satisfaction, health outcomes, and malpractice claims. This gap is addressed with a novel teaching tool for assessing nonverbal behavior using the acronym E.M.P.A.T.H.Y.- E: eye contact; M: muscles of facial expression; P: posture; A: affect; T: tone of voice; H: hearing the whole patient; Y: your response. This acronym was the cornerstone of a randomized controlled trial of empathy training at Massachusetts General Hospital, 2010-2012. Used as an easy-to-remember checklist, the acronym orients medical professionals to key aspects of perceiving and responding to nonverbal emotional cues. An urgent need exists to teach nonverbal aspects of communication as medical practices must be reoriented to the increasing cultural diversity represented by patients presenting for care. Where language proficiency may be limited, nonverbal communication becomes more crucial for understanding patients’ communications. Furthermore, even in the absence of cultural differences, many patients are reluctant to disagree with their clinicians, and subtle nonverbal cues may be the critical entry point for discussions leading to shared medical decisions. A detailed description of the E.M.P.A.T.H.Y. acronym and a brief summary of the literature that supports each component of the teaching tool are provided.

† Robertson K. (2005). **Active listening: more than just paying attention.** Reprinted from *Australian Family Physician*, 34(12)

Communication skills courses are an essential component of undergraduate and postgraduate training and effective communication skills are actively promoted by medical defence organisations as a means of decreasing litigation. This article discusses active listening, a difficult discipline for anyone to practise, and examines why this is particularly so for doctors. It draws together themes from key literature in the field of communication skills, and examines how these theories apply in general practice.

Rowland-Morin PA & Carroll JG. (1990). **Verbal communication skills and patient satisfaction: a study of doctor-patient interviews.** *Eval Health Prof*, 13(2):168-85

This research attempted to quantify specific behaviors in the physician’s initial interviewing style and relate them to patients’ perception of satisfaction. Five physicians were tape recorded during their initial interviews with 52 adult patients. The patients were asked to complete the Medical Interview Satisfaction Scale, a 29-item instrument with a 7-point response scale. These interviews were transcribed, timed, coded, and analyzed with the use of the Computerized Language Analysis System. Selected variables of the language dimensions were entered as the predictor variables in a multiple regression, along with satisfaction scores as the dependent variables. Twenty-seven percent of the variance ( $p$  less than .01) in the satisfaction scores of

initial interviews were explained by three aspects of a physician's language style: (a) use of silence or reaction time latency between speakers in an interview, (b) whether there was language reciprocity as determined through the reciprocal use of word-lists, and (c) the reflective use of interruptions within an interview. Considering the complexity of human communication, the fact that three variables were identified, which accounted for 27% of the variance in patients' satisfaction, is considered a substantial finding.

Ryan EB, Hamilton JM, et al. (1994). **Patronizing the old: how do younger and older adults respond to baby talk in the nursing home?** *International Journal of Aging & Human Development*, 39(1): 21-32.

To test the Communication Accommodation Theory for intergenerational talk to dependent older persons, eighty young adults and seventy-one older adults evaluated speakers in a brief taped conversation. Specifically, the study was conducted to determine whether the apparent nurturant quality of the baby talk tone of voice and parental style would compensate for the lack of respect associated with this type of patronizing talk to elders. The talk was either secondary baby talk or a neutral variant addressed to an elderly resident in the home by either a nurse or a volunteer. The caregivers who used baby talk were rated as significantly less respectful and competent than their peers in the neutral condition, but no differences were observed for nurturance of the caregiver. The recipients of baby talk were perceived to be less satisfied with the interaction. Findings were true for both caregiver roles and both respondent age groups. **OBJECTIVE:** To examine young adults' and older adults' evaluation of nurses' and volunteers' respectfulness, competence, and nurturance and nursing home residents' competence and satisfaction with care, based on audiotaped conversations in which caregivers used either "baby talk" (high pitch, exaggerated intonation) or neutral speech when interacting with a cognitively alert nursing home resident.

**DESIGN:** Survey

**SETTING:** University

**SUBJECTS:** 80 university undergraduates, 71 older adults.

**INTERVENTION:** Study participants listened to one of two audio-taped conversations, in which a caregiver tried to persuade a nursing home resident to come to dinner. Participants were provided with a written script describing the caregiver as either an experienced nurse or a new volunteer and the 85-year-old nursing home resident as cognitively alert.

**DATA COLLECTION:** Participants answered several 7-point Likert-type scale questions on a survey instrument. Items included evaluations of caregivers' nurturance (cold, supportive, distant, caring), competence (intelligent, incompetent), benevolence (helpful, trustworthy, unfriendly) and respectfulness (patronizing, respectful, polite, presumptuous) and of the nursing home residents' satisfaction with care (angry, satisfied, happy, frustrated) and competence (capable, healthy, active, alert, childlike). Speech was also rated on understandability, slowness, high pitch, exaggerated intonation, hesitation, softness, and shrillness.

**DATA ANALYSIS:** Multiple analysis of variance was used to assess the relationships between speech style, care provider role, and participant age group.

**FINDINGS:** Baby speech style was perceived as less respectful and less competent than neutral speech. Participant age and care provider role made no difference. Baby speech and neutral speech were perceived as equally nurturing. In the baby talk scenario, satisfaction with care was rated lower, while nursing home residents were not perceived as less competent. The nurse was rated more respectful and more competent than the volunteer, and was perceived as using less baby talk in both speech scenarios.

**CONCLUSIONS:** In general, nurses were rated more competent and respectful than volunteers, even when using baby talk. However, the use of baby talk was perceived as disrespectful and as a sign of caregiver incompetence. These negative assessments of baby talk were not counterbalanced by higher perceived nurturance or benevolence. Caregivers' use of baby talk did not influence the perception of nursing home residents' intelligence or capability, although it did reduce perceived satisfaction with care. This study indicates that caregivers should speak to nursing home residents as they would to any other adult. The authors recommend that

caregivers become more aware of their use of baby talk and reduce their use of this patronizing, controlling speech style, in order to improve patient care and satisfaction.

Schweikhart SB, Strasser S. (1993). **Service recovery in health care organizations.** *Hospital & Health Services Administration*, 38(1): 3-21.

Service recovery is defined as the part of quality management designed to alter the negative perceptions of dissatisfied consumers and to ultimately maintain a business relationship with these consumers. This article explores the theoretical and operational implications of service recovery in health services organizations. A framework that defines the range of possible service recovery actions is presented. Next, the benefits of and obstacles to service recovery in health services firms are discussed, and solutions for overcoming these obstacles are presented. Finally, the critical components of an effective service recovery program are described, and an agenda for empirical research on the efficacy of service recovery activities is proposed.

Schattner A, Rudin D & Jellin D. (2004). **Good physicians from the perspective of their patients.** *BMC Health Services Research*, Retrieved on Nov 21, 2005, from <http://www.pubmedcentral.gov/picrender.fcgi?tool=pmcentrez&blobtype=pdf&artid=520754>

**BACKGROUND:** It is not currently known what is the patient's viewpoint of a "good" physician. We set out to define patient's priorities regarding different physician's attributes in 3 domains important in medical care.

**METHODS:** Patients hospitalized or attending clinics at a large teaching hospital selected the 4 attributes that they considered most important out of 21 listed arbitrarily in a questionnaire. The questionnaire included 7 items each in the domains of patient autonomy, professional expertise and humanism.

**RESULTS:** Participating patients (n = 445, mean age 57.5 ± 16 years) selected professional expertise (50%), physician's patience and attentiveness (38% and 30%, respectively), and informing the patient, representing the patient's interests, being truthful and respecting patient's preferences (25–36% each) as the most essential attributes. Patient's selections were not significantly influenced by different demographic or clinical background. Selections of attributes in the domain of patient's autonomy were significantly more frequent and this was the preferred domain for 31% and as important as another domain for 16% – significantly more than the domain of professional expertise. (P = 0.008), and much more than the domain of humanism and support (P < 0.0005).

**CONCLUSIONS:** Patients studied want their physicians to be highly professional and expert clinicians and show humaneness and support, but their first priority is for the physician to respect their autonomy.

Shaw C, Williams K, Assassa PR & Jackson C (2000). **Patient satisfaction with urodynamics: a qualitative study.** *Journal of Advanced Nursing*, 32(6): 1356-1363.

This qualitative study was undertaken to assess patients' views of the urodynamic investigation. The aim was to identify the dimensions important to patients in evaluating satisfaction with this type of procedure and ways in which care could be improved. Unstructured interviews were carried out by four trained interviewers with 21 people (17 female and 4 male) who had undergone the urodynamic investigation at various gynaecology, urology and continence outpatient clinics. The interviews were audio-taped and transcribed verbatim. The data was then coded and a thematic analysis carried out. The main theme to emerge was focused on patients' feelings about the procedure. This consisted of a combination of anxiety and embarrassment. Anxiety was because of fear of the unknown and embarrassment at the intimate nature of the procedure and lack of privacy. The interpersonal and communication skills of the health care professional were central in alleviating these negative feelings. The establishment of a friendly relationship based on equality and mutual respect and trust was important in preventing anxiety and embarrassment. A number of practical issues were identified that would contribute to improving the service for patients. It was found that nurses possessed all the attributes required to provide an effective service and recommendations were made that nurses specializing in continence care should take a more active role in urodynamic

investigations.

**OBJECTIVE:** To identify the factors that influence patient satisfaction and the ways in which care delivery can be improved in the context of the urodynamic investigation.

**SETTING:** Patients were recruited from outpatient clinics where urodynamics investigations were carried out by a nurse and hospital clinics where the investigation was carried out by a doctor. Interviews were conducted in patients' homes.

**SUBJECTS:** n=21 (17 female, 4 male).

**DESIGN:** In-depth interviews.

**DATA COLLECTION:** Four trained interviewers conducted in-depth, hour-long interviews with the participants. Interviews were audiotaped and transcribed.

**DATA ANALYSIS:** The text was coded according to categories, including structure and process of care, views of illness, health care, views of the caregiver, feelings, individual characteristics, and caregivers' communication and interpersonal skills. Frequency of occurrence, relationships among the categories, and shared meaning and overlap between categories were used to develop a hierarchical coding frame.

**FINDINGS:** Patient feelings, including anxiety, embarrassment, and fear of the unknown were a major category. Health care providers' interpersonal skills, communication and information giving, maintenance of privacy, and technical skills reduced patients' anxiety and embarrassment.

**CONCLUSIONS:** Health care providers who acted friendly, relaxed, and informal helped establish a feeling of equality and relaxation among patients, particularly when the care provider and patient had established a trusting relationship at a prior visit or over the telephone. Care providers' communication skills, particularly active listening and the provision of adequate information, were essential for patient satisfaction. Information provision that utilized visual aids, such as brochures or posters, as well as verbal explanations helped patients understand the procedure and feel more comfortable. It was also important for health care providers to use appropriate language, neither too technical nor too patronizingly simple. Patient satisfaction was also improved when health care providers appeared unhurried and when they provided feedback regarding the procedure (i.e. what the procedure measured and how the patients' results compared to the standards). Maintenance of patient privacy also improved patient satisfaction, including being in a small room and having curtains that screened the examination area. Patient satisfaction was also influenced by patients' perception of the care providers' competence, which was indicated by care givers' confidence, efficiency, taking a full history, and willingness to answer questions.

Smoot SL, & Gonzales JL. (1995). **Cost-effective communication skills training for state hospital employees.** *Psychiatric Services*, 46(8): 819-822.

This study evaluated the cost-benefits of a staff communication training program designed to improve patient management skills and relieve staff stress. Staff on a short-stay adult inpatient recidivist unit received training, while those on a matched unit served as controls. Data were collected from routine reports 6 months before and after the training program. Results indicate that the trained unit had less staff turnover. The staff members of this unit used less sick and annual leave. Fewer patients' rights complaints were filed, and fewer assaults on staff were reported. Cost-benefit analysis revealed substantial savings for the trained unit and increased expenditure for the control unit. Results suggest that training in empathic communication skills for direct care staff is a cost effective approach to coping with staff stress and turnover and may improve patient outcomes.

**OBJECTIVE:** To evaluate the effect of a communication skills training program upon hospital staff's patient management skills, staff stress, and staff retention.

**DESIGN:** Quasi-experimental (intervention and control group), pre-test/ post-test.

**SETTING:** A short-stay adult inpatient psychiatric unit.

**SUBJECTS:** Staff of two inpatient psychiatric care units serving patients who had returned within one year of previous discharge; the intervention group had 35 staff and the control group had 37 staff.

**INTERVENTION:** Staff were trained in communication skills using the Carkhuff Human



Resources Development Model. The training focused on developing emotional and cognitive empathy to improve patient care and reduce caregivers' stress. The 32-hour program was held in sequential 8-hour sessions once a week for four weeks. Direct care staff as well as support staff received the training. The cognitive component of the training consisted of presenting a theoretical overview of the specific communication skill, a rationale for the promised effectiveness of the skill, and examples of the use of the skill (videotapes and instructor modeling). Role-playing allowed trainees to practice, receive feedback, and observe each other. Role-playing familiar patient-care scenarios elicited emotional reactions among the trainees. Empathy was taught by reflecting message meanings back to the speaker. Skills included attending to patients' communications, accurately reflecting messages' content and communicators' feelings, responding to patients' requests, and making requests in a respectful and empathic manner. Nonverbal body language, such as squarely facing a patient and using eye contact, was also taught. Trainees were taught to paraphrase the content and feeling behind patients' communications and to ask patients to verify their interpretation. Trainees were taught to respond respectfully to patient requests by paraphrasing, getting feedback, and explaining the rationale for complying or not with the patient's request. Staff were also trained how to make respectful requests by providing verbal and nonverbal reinforcement for compliance and to respond to noncompliance by giving a verbal warning about the consequences of noncompliance.

**DATA COLLECTION:** Monthly reports were used to collect data on staff turnover, hours of leave taken, number of patients' rights complaints, number of episodes of patient restraint and seclusion, and number of assaults by patients on staff six months before and six months after the communications skills training. Staff were surveyed one year later.

**DATA ANALYSIS:** Costs were calculated based on staff hourly wages, and time and supplies expenditures for events such as sick leave, hiring new staff, and investigations of patients' rights complaints.

**FINDINGS:** Staff retention, use of leave time, and patient outcomes improved in the intervention unit during the six months after the training compared to pre-test and to the control group. Expenditures on the intervention unit were reduced by \$62,592 while control unit expenditures increased by \$22,248. At one-year follow-up, all staff had received the training, and the positive satisfaction rate was 94% while 88% reported they treated patients differently, 86% reported patients were more cooperative, and 82% reported they showed more empathy to patients. Staff also requested refresher trainings, feedback on the unit, and a manual that they could refer to.

**CONCLUSIONS:** Communication skills training can improve health care providers' ability to empathize with patients, gain patient compliance, improve staff retention, and save the institution money.

Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW & Jordan J. (2000). **The impact of patient-centered care on outcomes.** *The Journal of Family Practice*, 49(9):796-804.

**OBJECTIVE:** To assess the association between patient-centered communication in primary care visits and subsequent health and medical care utilization.

**DESIGN:** Observational cohort study. Setting: Family Practices in London, Ontario, Canada and surrounding area. Subjects: 39 randomly selected family physicians (71.8% male, mean year of graduation was 1975); 315 patients (54% female, 60.3% married).

**MEASURES:** Outcomes measured included: 1) Patient's health, assessed by a visual analogue scale (VAS) on symptom discomfort and concern. 2) Self-report of health, using the Medical Outcomes Study Short Form-36 (multi-dimensional assessment). 3) Medical care utilization variables of diagnostic tests, referrals, and visits to the family physician, assessed by chart review. Office visits of the medical encounters were audio taped and scored for patient-centered communication (score based on 3 of the 6 components of the model of patient-centered medicine). In addition, patients were asked for their perceptions of the patient-centeredness of the visit (series of 14 times were used to assess patients' post-encounter perceptions of how patient centered the interaction had been).

**RESULTS:** Patient-centered communication scores were significantly correlated with the patients' perceptions of finding common ground. The total score of patients' perceptions that

the visit was patient-centered was associated with positive health outcomes. Patients who perceived that their visit had been patient centered received fewer diagnostic tests and referrals in the subsequent two months.

**CONCLUSIONS/RECOMMENDATIONS:** Patient-centered communication influences patients' health through perceptions that their visit was patient centered, and especially through perceptions that common ground was achieved with the physician. Patient-centered practice was associated with improved health status (less discomfort, less concern, and better mental health) and increased efficiency of care (fewer diagnostic tests and referrals). This finding is a concern for medical education and health care policy in that the patients' experience of being a participating member in the discussion of the problem and treatment process may translate into the patients' reduced need for further investigation or referral.

Taylor C, & Benger JR. (2004). **Patient satisfaction in emergency medicine.** *Emergency Med. Journal.* 21(5):528-532.

A systematic review was undertaken to identify published evidence relating to patient satisfaction in emergency medicine. Reviewed papers were divided into those that identified the factors influencing overall satisfaction in emergency department patients, and those in which a specific intervention was evaluated. Patient age and race influenced satisfaction in some, but not all, studies. Triage category was strongly correlated with satisfaction, but this also relates to waiting time. The three most frequently identified service factors were: interpersonal skills/staff attitudes; provision of information/explanation; perceived waiting times. Seven controlled intervention studies were found. These suggested that increased information on ED arrival, and training courses designed to improve staff attitudes and communication, are capable of improving patient satisfaction. None of the intervention studies looked specifically at the effect of reducing the perceived waiting time. Key interventions to improve patient satisfaction will be those that develop the interpersonal and attitudinal skills of staff, increase the information provided, and reduce the perceived waiting time. Future research should use a mixture of quantitative and qualitative methods to evaluate specific interventions.

Thompson DA, Yarnold PR, Williams DR & Adams SL. (1996). **Effects of actual waiting time, perceived waiting time, information Delivery, and Expressive Quality on Patient Satisfaction in the Emergency Department.** *Annals of Emergency Medicine,* 28(6): 657-665.

**OBJECTIVE:** To determine the effects of actual waiting time, perception of waiting time, information delivery, and expressive quality on patient satisfaction.

**METHODS:** During a 12-month study period, a questionnaire was administered by telephone to a random sample of patients who had presented to a suburban community hospital emergency department during the preceding 2 to 4 weeks. Respondents were asked several questions concerning waiting times (ie, time from triage until examination by the emergency physician and time from triage until discharge from the ED), information delivery (eg, explanations of procedures and delays), expressive quality (eg, courteousness, friendliness), and overall patient satisfaction.

**RESULTS:** There were 1,631 respondents. The perception that waiting times were less than expected was associated with a positive overall satisfaction rating for the ED encounter ( $P < .001$ ). Satisfaction with information delivery and with ED staff expressive quality were also positively associated with overall satisfaction during the ED encounter ( $P < .001$ ). Actual waiting times were not predictive of overall patient satisfaction ( $P = NS$ ).

**CONCLUSION:** Perceptions regarding waiting time, information delivery, and expressive quality predict overall patient satisfaction, but actual waiting times do not. Providing information, projecting expressive quality, and managing waiting time perceptions and expectations may be a more effective strategy to achieve improved patient satisfaction the ED than decreasing actual waiting time.

Thompson SC, Nanni C & Schwankovsky L. (1990). **Patient-oriented interventions to improve communication in a medical office visit.** *Health Psychology: Official Journal of the Div. of Health Psychology, American Psychological Assoc.*, 9(4) 390-404.

Examined a simple intervention to improve the patient's contribution to communication in a medical office visit. In the first study, women awaiting a medical appointment were randomly assigned either to a group that was asked to list three questions to ask their physician or to a control group. Women who listed questions asked more questions in the visit and reported being less anxious. In the second study, a third group that received a message from their physician encouraging question asking was added. Both experimental groups asked more of the questions they had wished to, had greater feelings of control, and were more satisfied with the visit in general and with the information they received. The two experimental groups did not differ significantly, suggesting that the effect may be attributed either to thinking one's questions out ahead of time or to the perception that one's physician is open to questions.

Thrasher C & Purc-Stephenson R. (2008). **Patient satisfaction with nurse practitioner care in emergency departments in Canada.** *Journal of the American Academy of Nurse Practitioners*, 20(5):231-237.

**PURPOSE:** To measure patient satisfaction with care delivered by nurse practitioners (NPs) in emergency departments (EDs) in Canada using a psychometrically valid survey.

**DATA SOURCES:** All patients who received care from an NP in six participating EDs in Ontario province over a 1-week period were asked to complete a self-administered patient satisfaction survey designed specifically to assess satisfaction with NP care in EDs.

**CONCLUSIONS:** One hundred and thirteen patients completed the survey. Principal components analysis of the survey revealed three factors or subscales: Attentiveness, Comprehensive care, and Role clarity. Scores on the three subscales indicated that patients were satisfied with Attentiveness (M= 3.72, SD = 0.38) and Comprehensive care (M= 3.52, SD = 0.49) and had a moderate understanding of Role clarity (M= 2.99, SD = 0.66). Participants with higher income levels reported higher levels of satisfaction with the attentiveness they received, whereas patients with previous experience with an NP reported higher levels of satisfaction with the comprehensive care they received. There was no appreciable increase in patient satisfaction with the NP based on age, gender, education, or health status. Implications for practice: These findings indicate that attentiveness, comprehensive care, and role clarity are reflected by the NP in emergency healthcare settings as indicated by the patient's responses to the survey. This study supports that meeting expectations is a critical component of patient satisfaction.

University of British Columbia (UBC) Health Services and Policy Research, Watson DE, Peterson S, Black C. **In pursuit of quality: opportunities to improve patient experiences in British Columbian emergency departments.** January 2009. Accessed online August 26, 2009 at <http://www.chspr.ubc.ca/research/patterns/emerg>.

In order to identify factors that drive positive or negative patient ratings of the overall quality of care in emergency departments, we used results of a province-wide survey completed by more than 16,800 patients who visited one of 110 facilities in BC in 2007 findings contain the following important lessons for ensuring that most patients in BC continue to report positive experiences and fewer patients report negative experiences: the factors that underlie patient ratings of both positive and negative reports of the overall quality of care in emergency departments are remarkably similar; the degree to which staff are considered to be courteous is the most important factor influencing patient ratings of quality; when health care professionals do well on factors that underlie these ratings, then patients offer high ratings of overall quality of care; and when health care professionals do poorly in those areas, patients are very likely to offer negative ratings of overall quality of the care they receive in emergency. Teamwork, comprehensive services, wait times to see a doctor, views on the reasonableness of that wait and availability of nurses matter also but not as much as the courteousness of staff.

van der Smagt-Duijnste ME, Hamers JPH, et al. (2001). **Relatives of hospitalized stroke patients: their needs for information, counseling and accessibility.** *Journal of Advanced Nursing*, 33(3): 307-315.

The purpose of this study is to explore the needs of stroke patients' relatives during the hospitalization period. In the Netherlands, the consequences of a stroke, and the needs of stroke patients and their relatives are becoming increasingly important. In hospital, however, nursing care is still focused on the patients. A previous qualitative study on the needs of relatives of stroke patients identified four categories of needs. This present study aims to test the results of the previous study in a larger setting and to identify the factors that influence the needs of the relatives. This study uses a cross-sectional design. A questionnaire was designed for the purpose of data collection. This questionnaire was completed by 106 relatives of stroke patients admitted to the neurology wards of 19 Dutch hospitals (response rate 64%). The data were analysed using descriptive and multivariate analyses. The findings of the study indicate that the needs of the relatives of stroke patients are best divided into three categories. These are the need for information, counseling (a combination of communication and support) and accessibility. In all cases, the most important need of the relatives of stroke patients is that their questions are answered honestly. The findings show a discrepancy between the importance of the needs and the degree to which these needs are met. Multivariate data analyses show that female relatives requested most information, whereas highly educated relatives needed less counseling. Satisfaction about the care provided is positively influenced by the period of hospitalization and negatively influenced by prior experiences of hospitalization.

**OBJECTIVE:** To identify needs of relatives of hospitalized stroke patients & factors that influence those needs.

**SETTING:** 17 general hospitals and 2 university medical centers in the Netherlands. Subjects: 163 stroke patients' relatives (106 responded).

**DESIGN:** Cross-sectional questionnaire.

**DATA COLLECTION:** Questionnaires were used to collect participant characteristics and demographic data, degree of need for information, communication, support, and accessibility, and their satisfaction with the degree that the needs had been met by health care professionals. Three-point Likert-type scales were used for each question.

**DATA ANALYSIS:** Reliability and validity were calculated. Communication and support were condensed into one category, counseling. Descriptive and multivariate analyses were conducted.

**FINDINGS:** The need for information was very high among the respondents. However, 50% of respondents did not receive the information they needed about their relatives' condition. Counseling needs were slightly less important than information needs, and the respondents were generally satisfied with the provision of support and communication. As far as accessibility, 98% of the relatives found it very important that health professionals take the time to answer their questions and that they should have access to their relatives' neurologist. However, 84% of the relatives were satisfied with their access. Female relatives attached greater importance to their need for information than did male relatives. The need for counseling was influenced by relatives' education level; those with higher education reported less need for counseling. However, those who had previously experienced a relative having a stroke reported greater need for counseling and accessibility. Patient spouses/partners younger than 61 expressed greater need for accessibility to health care providers than other groups. In general, relatives of patients who spent 8-30 days in the hospital or who had other illnesses received more information than relatives of otherwise healthy patients or patients who stayed less than 8 days.

**CONCLUSIONS:** The most important need for stroke patients' relatives was the need for health professionals to answer their questions honestly. Information needs were rated most highly, although only half of these needs were adequately met. The authors suggest that nurses learn to be more aware of the needs of patients' relatives and to develop strategies and/or practice guidelines to meet these needs.



Vivian BG, & Wilcox JR. (2000). **Compliance communication in home health care: a mutually reciprocal process.** *Qualitative Health Research*, 10(1): 103-116.

The study described in this article examined the process of compliance gaining in home health care. The investigation focused on nurse-patient communication and the relational and content aspects of compliance communication. Six registered nurses and 25 adult patients from two cooperating home care agencies participated in this study. Observation during home visits and interviews with nurses and patients revealed a prosocial, collaborative model of compliance gaining. The findings show compliance communication to be embedded in nurse-patient conversations, with both nurse and patient engaging in control and affiliative behaviors. Implications for compliance research and the mutual-participation model of medical care are discussed.

**OBJECTIVE:** To identify the ways in which visiting home care nurses and their patients communicate to achieve compliance-related goals.

**SETTING:** Two home health care agencies in the Midwestern United States.

**SUBJECTS:** 6 registered nurses, 25 adult patients.

**DESIGN:** participant observation.

**DATA COLLECTION:** Investigators accompanied the nurses on a day of rounds to observe nurse-patient interaction. Next, nurses were interviewed informally between visits and at the day's end. Semi-structured face-to-face interviews were conducted with the nurses to discuss their descriptions of home care, perceptions of patient needs, perceptions of the nurse's role and responsibilities in home care, and their views on compliance (strategies and expectations). Patients and their families were interviewed over the telephone. Five immediacy behaviors (eye contact, physical proximity, body lean, body orientation, and touch), as well as instances of verbal confirmation, and validating communications, were observed and recorded.

**DATA ANALYSIS:** Written notes on the interviews and observations were analyzed for themes related to nurse-patient communication and compliance-gaining behaviors, internal consistency, similarities and differences between interviews, and consistency between self-reports and actual behavior.

**FINDINGS:** Self-report and actual behavior were generally consistent. However, patients and family members rarely admitted to having compliance problems despite nurses reporting problems, and nurses reported a more comprehensive role in promoting compliant behavior than was reported by patients and family members. Five categories of compliance communication were identified: educating patients and family members, arranging support services, removing obstacles to compliance, providing positive reinforcement or rewards, and using threats or scare tactics. Education was the most frequently observed communication behavior observed during home visits, and usually followed a question-answer format. Nurses asked whether patients had any questions or problems, and patients and family members asked for information, explanations, help, and advice. Nurse compliance-gaining communication behaviors also include providing instruction accompanied by explanations, reminders, repetition of instructions, patient demonstrations of the medical procedure, and written information. Nurses provided information about sources of support and services that would enable and reinforce patient compliance. Nurses removed obstacles to compliance; for example, devising a coding scheme for medication schedules, discussing treatment plans with the patient's physician, or adjusting the plan to the patient's lifestyle. Positive reinforcement was rare, but took the form of praise or small gifts. Only one threat was observed, and it took the form of explaining the positive consequences of compliance versus the negative consequences of non-compliance. Compliance communications and behaviors were embedded in nurse-patient interactions. Nurses' affiliative behaviors, such as listening, validating the patient's self-worth, and being caring, supportive, and empathetic created a trusting and respectful relationship between nurses and patients which supported patient compliance and helped nurses tailor caregiving to the individual's needs. Nurse roles and responsibilities were clear, and there were few struggles with dominance or control. Nurses supported patient autonomy by encouraging decision-making, asking for patients' perspectives, and providing information.

**CONCLUSIONS:** Educating patients by providing information, discussing the care regimens and their purpose, and by providing opportunities for patients to incrementally develop self-care

skills, within the context of a respectful, supportive relationship, were the main ways nurses promoted patient compliance with treatment regimens.

Ward J & McMurray R. (2011). **The unspoken work of general practitioner receptionists: A re-examination of emotion management in primary care.** *Social Science & Medicine*, 72(10): 1583-1587

Suggests that GP receptionists perform complex forms of emotion management pursuant to facilitating efficacious care. Identifies two new emotion management techniques: emotional neutrality and emotion switching. Calls for emotion management research to move beyond core occupations to reconsider the complexity of ancillary work. This research article was reviewed and summarized in the New York Times on July 5, 2011 by Pauline W. Chen.

Weslien M, Nilstun T, Lundqvist A & Fridlund B. (2005). **When the unreal becomes real: Family members' experiences of cardiac arrest.** *Nursing in Critical Care*, 10(1):15-22.

The aim of this study was to provide insight into family members' experiences related to cardiac arrest. Data were collected through semi-structured interviews with 17 family members approximately 5-34 months after the cardiac arrest of a relative. As the focus was on the family members' experiences seen from a holistic perspective, content analysis was chosen for the study. When the event occurred to the patient, family members realized the need for assistance and managed to initiate first actions. When the emergency medical service arrived, family members responded to stress and forgot their own needs. When the staff took over at the hospital, family members not only received sympathy but also encountered professional distancing. Because their experiences vary widely, the encounter has to be developed through a comforting, sympathetic and respectful dialogue in consideration for individuals' preferences.

Wiman E & Wikblad K. (2004). **Caring and uncaring encounters in nursing in an emergency department.** *Journal of Clinical Nursing*. 13(4):422-429.

**BACKGROUND:** Caring is a core characteristic of nursing. Nurses' caring behaviour has been explored in several studies. When caring for trauma patients, the most important caring behaviour must be the procedures associated with lifesaving. However, it is important not to forget the patient's psychological needs.

**AIM:** The aim of this study was to highlight encounters between injured patients and nurses in the trauma team and to explore whether the theory of caring and uncaring encounters in nursing and health care is applicable in emergency care. **Data collection and analysis:** Data were collected by videotaping caring episodes between slightly injured patients and nurses in the trauma team. Five episodes involving 10 nurses were studied. The analysis was carried out in four steps. First the videotapes were studied several times and then transcribed into narratives, which were reduced into courses of events. These were subsequently classified according to aspects of caring and uncaring.

**RESULTS:** The nurses' verbal and non-verbal communication was poor, and they adopted a wait-and-see policy. A new uncaring aspect, instrumental behaviour, emerged from this poor communication. One of the caring aspects, being dedicated and having courage to be appropriately involved, could not be identified. Most encounters included several aspects of caring and uncaring, but the uncaring aspects predominated. The dominance of uncaring aspects indicates a lack of affective caring behavior.

**CONCLUSION:** The result showed that the theory is partly applicable in emergency care. A new aspect, instrumental behavior emerged. The nurses' behavior in the five episodes was labeled as uncaring. Authentic nurse-patient encounters are essential in nursing. **Relevance to clinical practice:** The importance of meeting patients' psychological needs and nurses' affective caring behavior should be emphasized in trauma care, trauma courses and nursing education. It is necessary to measure the caring behavior of trauma nurses.

Wolff JL & Roter DL. (2008). **Hidden in plain sight: medical visit companions as a resource for vulnerable older Adults.** *Arch Intern Med*, 168(13):1409-1415

**BACKGROUND:** Sicker patients are less satisfied with the quality of health care they receive than their healthier counterparts.

**METHODS:** A sample of 12 018 community-dwelling Medicare beneficiaries 65 years or older from the 2004 Medicare Current Beneficiary Survey was studied. Multivariate regression was used to describe whether beneficiaries' self-reported satisfaction with their usual-care physician was related to the presence or functions assumed by visit companions.

**RESULTS:** Overall, 38.6% of beneficiaries reported being typically accompanied to routine medical visits. Accompanied beneficiaries were older, less educated, and in worse health than their unaccompanied counterparts. More than 60% of companions facilitated visit communication by recording physician instructions (44.1%), providing information regarding patients' medical conditions or needs (41.6%), asking questions (41.1%), or explaining physicians' instructions (29.7%). After controlling for sociodemographic and health differences, accompanied beneficiaries were more highly satisfied with their physician's technical skills (odds ratio [OR], 1.15; 95% confidence interval [CI], 1.02-1.30), information giving (OR, 1.19; 95% CI, 1.05-1.35), and interpersonal skills (OR, 1.18; 95% CI, 1.03-1.35) than unaccompanied beneficiaries. Accompanied beneficiaries whose visit companions were more actively engaged in communication rated physician information giving (OR, 1.42; 95% CI, 1.14-1.77) and interpersonal skills (OR, 1.29; 95% CI, 1.05-1.59) more favorably. This relationship was strongest among beneficiaries with the worst self-rated health.

**CONCLUSIONS:** Visit companions are commonly present in older adults' routine medical encounters, actively engaged in care processes, and influential to patients' satisfaction with physician care. More systematic recognition and integration of visit companions in health care processes may benefit quality of care for a particularly vulnerable patient population.

# Treating Patients with C.A.R.E.: Keller and Baker

<sup>1</sup>C.A.R.E.

by

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## INTRODUCTION

Since the beginning of the nineteen nineties, there has been a lot of talk about customer satisfaction in health care. Competition to enroll and retain patients can be fierce. This is new. But, then, everything in health care seems to be changing. Patients complain that health care is becoming too commercial, too business-like. Even the labels of those who take care of us have changed. Where once we had a doctor or a nurse, we now have a provider.

People who work in health care also complain that it has become too commercial. Certainly the commercialization of health care has brought with it a great deal of cynicism whenever the question of patient satisfaction, or customer satisfaction, comes up. Members of the health care team wonder, realistically, if they aren't being viewed the same way as someone who works in a department store or a car dealership.

Health care, though, is different. Those of us who work in health care know that in every fiber of our body. The stakes are higher, much higher. Saying that health care is different doesn't demean people working in other arenas, but it is important to recognize that no matter how commercial health care gets, it is different. Patients come to us with diseases or injuries that can cause pain and suffering. They come to us having had their lives disrupted by illness: they can't work or take care of their children or spouse. They come to us with fears for their lives and those of the members of their families. Communicating with patients is different. It is not the same as talking to the person buying a hamburger, paying their telephone bill, looking for a parking place or trying on a new pair of shoes. The stakes are higher and more personal.

Every member of the health care team who communicates with patients knows the stakes are higher whether it is the guard at the entrance to a facility or the medical assistant preparing the patient for the physician. Directions on how to get to radiology, explaining how a complicated billing process works, making an appointment for a surgery or welcoming a new patient to a strange environment are all part of the health care process. These seemingly simple conversations make a patient feel welcome or a burden, increase or decrease anxiety, inspire confidence or add to worry.

Health outcomes are affected by how the members of the health care team talk to patients. *"I'm not going back there; they treat you like dirt,"* may mean that a patient doesn't get the proper monitoring of his or her blood sugar level and the patient suffers from the complications of diabetes. Wandering around a hospital looking for the right office may mean that an important test doesn't get done and a cancer diagnosis is made too late.

Communicating with patients is different. The responsibility of every member of the health care team to communicate effectively is greater than in other jobs. What does this mean, though, for what we do on a day-to-day basis? How can a member of the health care team check to make sure they are communicating effectively with patients?

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## A Model for Communicating with Patients

In the real estate world, there is a saying that what matters most in determining the value of a home is location, location, location. In the health care world, what matters most in communicating with patients is attitude, attitude, attitude. The attitude that must be communicated is, "I care!" When patients feel they are respected, seen as individuals, listened to and talking to someone who wants to help them, they feel cared for.

"I care." It sounds simple. Many members of the health care team report, though, that they feel that way, but they aren't sure they are as effective communicating this attitude to patients as they want to be. To help develop effective skills communicating with patients, a four-step process has been developed that uses the word C.A.R.E. to make it easy to remember both the attitude and the steps that are involved in effective communication in the health care setting. C.A.R.E.: (1) *Connect* with the patient, (2) *Appreciate* the patient's situation, (3) *Respond* to what the patient needs, and (4) *Empower* the patient to problem-solve with you - C.A.R.E.

In health care, more than in other work situations, it is important to have a specific process in mind for two reasons. First, many of the conversations that take place in health care are very short, sometimes lasting less than a minute. Yet, within that minute, it is often important to use all four steps of the C.A.R.E. process.

Second, members of the health care team are often working with patients who are in pain, scared or feeling abandoned. Most of us are not at our best when we are feeling like this. We may act badly. It is not unusual for a patient to seem to be very demanding, forgetful, angry or passive. When patients act this way, though, most often they are communicating some underlying distress. These behaviors are often a symptom in the same way fever may signal the presence of an infection.

When confronted with patients acting in these ways, it is critical that every member of the health care team use effective communication. To respond spontaneously, the way we might to a stranger on the street who acts badly, is to make the situation worse, and sometimes to cause harm.

A caring attitude is communicated through action - what, then, are actions that communicate a caring attitude? Each of the action steps of the C.A.R.E. process is described, with examples, in the sections that follow.

### CONNECT with the Patient

We have all had the experience of trying to talk to someone who is not paying attention to us; there is no connection. It is frustrating. We feel like a nothing, a bother, a burden, a non-person. At times it can get so bad that we want to tap on the person's head and say, "*Hello, I'm here. Do you see me? Do you hear me? Do you care whether I'm here or not?*"

**A patient is a person, not a task.** When referring to patient admissions in a hospital, especially at night, doctors and nurses often talk of patients as "hits." "*We had six hits last night.*" One experienced physician reported during an interview that this negative attitude towards patients changed for him at some time during his residency:

*"But, it's hard to say exactly, it was just sort of something that sort of dawned on me and something that I started sort of noticing was that there is something basically not right about this. I have to have some sense of calling to be doing this for the good of people instead of developing an attitude about them that makes them perpetrators instead of patients."*

Too often, patients are treated as perpetrators whose crime is that they are causing work for the staff rather than patients who need our information and our expertise. Or, as one nurse put it when talking to a complaining co-worker: "*The patients didn't make out the schedule!*"

Treating patients as perpetrators rather than patients is most often seen when members of the health care team don't connect to the patient. They do the task, but don't connect. The patient becomes an object, an arm to draw blood from, a body that sits behind the dinner tray to be collected, a question to be answered.

When the team member does connect with the patient, the patient notices. An elderly woman who was hospitalized made the following statement to a nurse: *“That young man who brings in dinner is so sweet. He always remembers my name and knows that I have a hard time sitting up. He doesn’t leave until I am comfortable and can reach my food.”*

The first action step in C.A.R.E., then, is to **CONNECT** with the patient as a unique human being. It is easy to do. There are some very simple things we know from research and personal experience that help us to connect with another person.

**Establish eye contact.** This is so simple, yet it often doesn’t take place. With some jobs, it is easy to forget to establish eye contact because we are writing or reading from a chart or a computer screen while we are trying to talk to the patient. We may forget to look at the person. There is a gimmick; it’s a bit corny, but it helps. Ask yourself: “What color eyes and hair does this patient have?” It is very difficult to answer these questions and not make eye contact with a person.

**Be formal.** This surprises some people. Having the right to be familiar and refer to people by their first name comes with time and cannot be assumed. Patients should be called Ms. or Mr. until they tell you to do otherwise. It is respectful. Many more people are offended by being called by their first names than are offended by being addressed with the respectful Mr. or Ms. Formality should be used even if the patient calls you by your first name. Formality should be used until the patient asks you to change how you address him or her.

Never use terms of endearment with a patient: honey, sweetie, cutie, etc. Even when the patient is a child, it is best to use the patient’s name. When we see children, parents are usually present. It is respectful to both parent and child to reserve the terms of endearment for family members and friends to use as an acknowledgment of their special relationship.

Similarly, never use terms of endearment with older patients. This is very disrespectful. As we age, our ability to care for ourselves diminishes, as our bodies become physically weaker and less able to fight off disease or recover quickly from injuries. We do become more dependent upon others for help. However, our life experience and our wisdom don’t depart unless dementia is present. Formality should be used in addressing older patients out of respect for who they are and who they have been.

One reason for avoiding terms of endearment is that they are emotionally loaded. They say, “You and I have a special relationship.” Some people in health care feel that the use of terms of endearment is their way of communicating that they care. However, these terms may be insulting to the patient or to the people who really do have special relationships with the patient: spouses, parents, children, friends. Again, calling someone honey or sweetie may offend the patient or someone special in the patient’s life. Referring to the patient by the appropriate name never offends.

**Watch your tone of voice.** Our parents admonished most of us to “*watch your tone of voice*” when we were young. If we have our own children, we have probably said the same thing at one time or another. There was and is tremendous truth in that admonishment.

In a series of research studies, audiotapes were made of people interacting with one another in a work setting. Through an electronic mechanism, the tapes were altered so the words couldn’t be understood, but you could still hear the tone of voice. It was similar to listening to the voices of people talking on the other side of a wall. People who listened to the audiotapes of the voice tones were able to predict, on tone of voice alone, how satisfied people were with the interactions and services they were receiving. To put it simply, “Warmth wins!”

Warmth especially wins when greeting someone or when you are asked to provide information on the fly:

*“Good morning, Mr. Smith. It’s good to see you.”*

*“O.K., you’re trying to find the radiology department to get your x-ray done; let me think about the easiest way for you to get there.”*

Eye contact, warmth, the use of an appropriate name and treating someone like the patient; they are, rather than a perpetrator, all elements of connecting to the patient. They are all ways of making sure the patient won't fantasize about tapping on our head and saying: *"Hello, I'm here. Do you see me? Do you hear me? Do you care whether I'm here or not?"*

### **APPRECIATE the Patient's Situation**

Patients are always dealing with two distinct situations when they come to us for health care. First, they have to face whatever challenges their bodies or circumstances have presented them. Inevitably, these challenges include disruptions in their lives. The disruptions might include obvious elements like pain or discomfort. They might include less obvious ones like uncertainty and anxiety. The challenges they have to face include all of those associated consequences of a health problem that frequently come as an unwanted surprise.

We are all acquainted with the way illness changes our lives, however temporary the change may be. We can't go to a party because we get the flu or a wonderful vacation is strained because one of our children gets severe sunburn and can't go to the beach with the rest of the family. Patients who come into our facility have had his or her life changed in some way, whether big or small, because of their illness. As a medical assistant said, *"We aren't selling hot dogs; we're taking care of people."*

Second, the patient has another situation to deal with: the health care system. It can be complicated, mystifying and feel like another country where everyone speaks a foreign language. There are medical dictionaries filled with words that only people working in health care use on a daily basis. We also have an alphabet soup of letters and words that have unique meanings. Where else does coronary artery by-pass graft become C.A.B.G. and is referred to as a cabbage: *"The patient in 607 had a cabbage three days ago."*

A strange language, strange requirements (understanding what is covered and not covered in most health plans is a full-time job itself), a strange setting and a constant bombardment of surprises makes most health care encounters fraught with difficulty: *"I expected to see the doctor at 9:30. Now I'm told that it could be 10:00. I need to pick my kids up at 10:30."*

Appreciating that the patient is dealing with two difficult situations (the health problem and the life problem) is critical. We can do three things to express our appreciation for the patient's situation.

**Listen carefully.** Every patient is unique. What happens to patients differs from patient to patient. How patients experience things also differs. What is easy for one patient might be very difficult for another. It is essential that we listen carefully to what patients are telling us. There are barriers, though, to doing that.

The biggest barrier is when we are thinking to ourselves and getting ready to say something back to the patient rather than listening. We have all had the experience of this with little children who are slow in getting out what they have to say. We are tempted to finish sentences for them or even to say, *"Come on, get it out."* We do this because our experience is greater and because we have tasks to do. The same barrier crops up in the health care setting. We know the medical world better than patients do. We know the policies and the practices. It is easy to finish sentences or start to talk before the patient has finished what he or she is saying. There are some things we can do to overcome these barriers.

First, we can focus on what the person is saying to us. What is the question this person is asking? What are their concerns? One way we can discipline ourselves to focus is to ask them questions rather than giving them answers right away.

A second way we can focus is by using a technique called reflective listening. When we do reflective listening, we act as a mirror for the patient. We say something to the patient that summarizes or compresses what they are trying to tell us. Sometimes it is easiest to preface this by saying something like, *"If I understand you . . ."* and then telling the person what your understanding

is. For example, *“If I understand you, the office called and said that you were to be here at 9:30 for your test, you arrived on time and were told that you had no test scheduled today.”*

Listening is not easy. Sometimes it can be very hard work. However, no activity we can engage in conveys caring more forcefully than listening carefully.

***Understand the patient’s point of view.*** Novels, movies and plays have been written about the idea that people see things differently depending upon their point of view. Imagine the following situation.

We have been visiting relatives and are on our way home, but find ourselves stranded at the airport because of a snowstorm. At home, we are to be picked up by a member of our family. They have already left to go get us. We are worried about reaching them. The staff member at the airline counter has a hundred and twenty passengers he is trying to find seats for on later flights. He has to find hotel space for those who want to stay over and try to get out in the morning. Passengers are bombarding him with questions and treating him as though he alone was responsible for the snowfall. Two totally different points of view exist — this is a situation just ripe for bad communication.

Understanding the patient’s point of view requires that first we listen to the patient and work hard to make sure we are hearing what the patient is saying. Then we have to try to understand what it is like for that patient to be in the situation that he or she is in. To do this, we have to get outside of our own needs and ourselves. As one person put it, *“Understanding another person’s point of view means that you have to hit the pause button on what’s important to you.”* We have to put our own needs on “pause” so we can understand what it is like to be the patient right now. If we can do this, we can usually see the situation from the patient’s point of view. As we do so, we may be able to understand what the patient is thinking and feeling.

***Acknowledge and express concern.*** There is a difference between observing and witnessing. An observer might see an event take place, be aware of the distress that people are experiencing and never say a word. A witness, on the other hand, sees what is taking place, is aware of what is happening to others and then openly acknowledges what he or she is seeing and expresses concern. In human interaction, silence is sometimes not golden. We have all had the experience of trying to tell someone something that is important to us and all we get in return is a kind of stone silence. Most of us interpret that kind of non-response as: *“He or she doesn’t care.”*

Appreciating the situation of the patient calls upon us to not simply listen and understand, but to act. The action needed is simply acknowledging to the patient that we understand the situation, how the situation is affecting them and our own concern about it. *“It sounds like you are really worried that your family is out driving in this snowstorm and you can’t reach them to let them know that the flight won’t be coming in tonight, and you are frustrated because you have no way of reaching them. I understand why you are upset about this. Let’s see if we can figure out some way to get in touch with them.”*

Appreciating the situation, then, calls upon us to listen attentively to the patient, understand his or her point of view about the situation, acknowledge that we understand the patient’s situation and express our own concern and willingness to work with him or her.

## **RESPOND To The Patient**

You ask somebody a question and they give you an answer that has nothing to do with the question you just asked. We have all had that experience. Newspaper people talk about the “non-denial denial.” The reporter asks a politician if he or she is affirming or denying something and rather than deny it, the politician talks about something else and totally avoids the question. An answer has been given, but it is non-responsive. Patients have questions and concerns that our response. They also need us to anticipate the questions and concerns they are going to have.

***Listen carefully.*** When working with patients we often give our version of the non-denial denial. We don’t answer the question. We may want to respond, but give an inadequate response because we didn’t listen carefully to what the patient was saying. We may give an answer that has



little to do with what the patient asked. So, the first task is to listen carefully and to ask us, “What is this patient asking?”

There are times that we may have a hunch that the patient is asking one question, but really wants an answer to another. When this is the case, it is best to answer both questions or at least to let the patient know we have heard both questions. “*Will my father be able to come home on Saturday?*” might really mean, “*Is my father going to be O.K.?*” We might answer: “*Your father is recuperating nicely and, if things keep going the way they are, he’ll be able to go home Saturday or possibly Sunday.*” Sometimes a patient will ask a question and we have a hunch that he or she is really making a statement rather than asking a question: “*Do patients complain about the food here?*” This might really mean, “*This food is terrible.*” We might answer, “*Yes some do. Others are actually a bit surprised and say they like it. What are your thoughts about the food so far?*”

**Clarify what is being asked when you are in doubt.** It is not unusual to be asked a question that confuses us. We are not sure, even when we are paying attention and listening carefully to what the patient is saying. Rather than guess or make assumptions, ask for clarification. “*We have several clinics today. I am not sure which clinic you would like me to direct you to. I’d hate to send you off to the wrong place. If you tell me who the doctor is you are going to see or what the problem is, I can get you to the right place.*”

Sometimes simple reflective responses will be enough to let the patient know you need more information before you can be helpful. In using a reflective response, we can indicate that our response is really a question by how we end the sentence. If our tone goes up at the end, it lets the patient know we are asking for clarification.

*“Can you tell me if this procedure will be completely covered or will I have to pay a co-pay?”*

*“This procedure?”*

*“Yeah, this sigmoid something I’m supposed to have.”*

*“Your doctor wants you to have a flexible sigmoidoscopy and you want to know whether there is a co-pay.”*

*“Yeah, that’s it.”*

This example introduces another problem that we all have in the medical world: language. A clinician may use language that is completely unintelligible to the patient and all the patient hears is, “sigmoid something.” The patient is in a bad position because he or she can’t even ask a question using the words of the medical world in which they are trying to get the information. We frequently have to act as an interpreter. We have to translate the medical language into everyday language so the patient can understand.

Our own responses must also be in everyday language. “*You’re going to the A21 building,*” is meaningless to the patient who has never been in the complex before. “*You’re going to go to the last building on top of the hill. The main entrance is right in front of the flag pole,*” stands a better chance of getting the patient to where he or she is trying to go.

Listening carefully, clarifying what the patient is asking and using everyday language are the first steps in being able to respond appropriately and completely to patients. The next steps, though, are a bit more difficult.

**Rules are one thing, but judgment is everything.** Every organization has rules. Most of them make sense. Some, though, were developed as a response to a specific situation and may or may not make sense at the current time. Or the rule may make sense for most of the people they were developed for, but may not make sense in a specific instance. For example, a handicapped golfer who was functionally immobile had been prohibited from using a golf cart to move about the golf course because the rules of the Professional Golf Association said that in tournament play you had to walk from hole to hole. In order to compete professionally, the golfer had to take his case all the way through the court system to show that the rule should not be applied to him. He did so — successfully.

There is a temptation, though, to simply state what the rule or policy is without regard for the impact of the policy or rule on the patient standing in front of you. When we do so, we often give a non-response. In fact, the patient may already know the rule or policy. But it puts the patient in a bind and the patient is asking us to help him or her to solve the problem.

However, some policies and rules are in the patient's best interest. Therefore, the task is to do three things: (1) recognize that there is a problem, (2) state the rule and why it was developed and how it was designed to respond to the needs of the patient, and (3) discuss options for solving the problem.

The important thing is to avoid communicating to the patient that all we are interested in doing is stating the rule or policy. Even when we don't have much room to bend the rule or policy, if we let the patient know that we are interested in the problem that the rule or policy is causing for them, most patients will work constructively with us.

**Offer possible solutions.** When we are called upon to respond to patients it is almost always to solve a problem. *"I don't know how to get from here to there."* *"I don't understand this."* *"I am uncomfortable or scared."* Every member of the health care team is a problem solver. In fact, one way of looking at your job, any job, is to ask: *"What problems am I expected to solve?"* A difficulty may develop when the problem a patient asks us to solve is not one that we think of as part of our job. We may feel that we don't have the knowledge or the authority to solve the problem. In those situations, it is often tempting to be polite, but non-responsive: *"I'm sorry, I can't help you with that."*

That leaves the patient with the problem. If, on the other hand, every member of the team defines his or her job in terms of helping patients solve problems, then responding takes on a different dimension. Without the right knowledge or authority, the solution I provide may simply be to help the patient get to the person with the knowledge or authority. However, this can be done abruptly: *"You'll have to talk to the billing clerk about that."* Or, it can be done in a helpful way: *"I'm sorry I can't help you with that. The billing clerk will be able to, though. That office is right down at the end of the corridor. Someone should be there now who can answer your questions."*

**Finding help when you can't.** There are times when we don't know where to direct a patient. It would be easy to simply tell the patient that, *"I don't know where that office is."* Again, that leaves the patient with the problem. Instead, we can seek out help from someone who can help the patient: *"Let me call security for you; they have a map of all of the names and offices and should be able to tell you where to go."*

Many of the approaches to responding to patients so far have dealt with reactions to problems presented to us by patients. However, we can also be proactive in our responses.

**Creating expectations.** First-time fliers are frequently nervous as they board the airplane. Once on board, they get safety instructions, which often add to their anxiety. Then the plane takes off and makes sounds and does things that often surprise the first-timers and makes them even more anxious.

Much of this anxiety could be relieved if the first timers were told what to expect. *"Once we get off the ground, you will hear the wheels coming up and then a thudding sound as the doors that cover the wheels close. Shortly after that, you will hear another sound and, if you look out on to the wings, you will see the back portion of the wings retracting into the main part of the wing. These are called flaps and are used for taking off and landing."*

Setting expectations is a way of avoiding the anxiety that comes with the unfamiliar and being vulnerable. *"You've never had blood taken from your arm before. We call it drawing blood. Let me explain how it works. First, I am going to tie an elastic..."*

Sometimes the expectation setting is of a different kind: *"You will get a statement in a month describing all of the medicines that were used and each of the services that you received. Some of these will be abbreviations, but on the back of the form are explanations for each of the abbreviations. The final item on the form will be the total amount, what your eligibility covers in your situation and what you are expected to pay. If you have any questions, please give me a call."*

When we are setting expectations, we are trying to avoid problems for the patient by helping the patient to understand and to negotiate what is often a foreign and threatening situation. The goal of being responsive, then, is to solve problems and to anticipate and avoid problems. We need to talk to the patient to do both.

### **EMPOWER the Patient**

Most health care is provided by patients. Some estimates are that patients provide up to ninety percent of the health care they receive. Fevers are treated, sprains taken care of, splinters removed and on and on. In rural areas that are not served by professionals, older members of the community often serve as repositories of the folk wisdom of healing and are called upon to treat members of the community. Life expectancy in Boston, one of the most medically served cities in the world, is shorter than non-served hamlets in the Himalayas. Obviously, there are all sorts of reasons for this, but it does emphasize that professional care is not the only element in healthy living.

Recent studies have demonstrated that the more active a patient is in his or her own care, the better the health outcomes. Empowering patients, then, is not simply a matter of being politically correct, or a strategy to reduce the burden on the medical team; it is a way of improving the health of our patients. There are several elements to it.

***Empowerment begins with connection and appreciation.*** If we are to work with a patient in a way that we draw upon his or her resources to solve problems, we have to have a relationship that enables us to work with the patient collaboratively. We can't do this in a vacuum. A great deal of research on how to motivate patients shows that the first step is building rapport: connecting with the patient as a person and learning about and appreciating the situation that he or she is in.

***Work as partners.*** Empowering a patient doesn't mean that the members of the health team withdraw from the patient. Instead, empowering means that the members of the team recognize that the patient, in most situations, has resources that are important to resolving whatever the problem is. When patients are too fragile, old or young to participate, they usually have caregivers that have important resources. The task for members of the health care team is to work with the patients or caregivers to clarify the problems, identify the resources needed to resolve the problems and together develop a plan.

The shift in thinking is the movement from an assumption of patient helplessness to an assumption and acknowledgment of patient resourcefulness and competence. Members of the health care team can actually train patients to be helpless, learned helplessness, rather than expecting them to be competent and autonomous. Specific techniques can help members of the team act on the assumption of patient competence and resourcefulness.

***Use "we" language.*** Rather than continuously emphasizing what members of the health care team are going to do for the patient, "we" language explicitly creates the expectation of a partnership. For example, "Let's think this through together," is a very different message than "Here's what I am going to do." Using "we" language doesn't ignore the fact that the members of the health care team may have more expertise to solve a given problem, but it doesn't assume that the patient has none.

This can be translated into very simple kinds of problem solving. For example, "*You haven't been to our facility before. Let me explain how this works. If I am giving you more information than you need, just let me know.*" This is "we" talk. It assumes that the patient is competent to determine how much information she or he needs to solve the problem.

***Convey that questions are helpful.*** We have all had the experience of asking someone a question and the response we get makes it very clear to us that the staff member considers our question to be inappropriate or an intrusion on whatever he or she is doing. However, asking questions is a way of being responsible for oneself and solving one's problems. It is a way of acting on our competence because we need information.

When we empower patients, we make ourselves available for questions: "*Your questions are helpful, please don't hesitate to ask them.*" "*When you think of any questions, don't hesitate to write*

*them down and bring them with you.*" These approaches wind up saving time later on because the information we are providing is enabling the patient to be more competent.

Sometimes questions communicate a challenge. There is an edge of, "Why do we have to do it that way." We can feel defensive. When we empower patients, though, we also assume that they are capable of seeing our point of view if we express it clearly. It doesn't mean that they will necessarily agree with us, but it does assume that two-way communication can take place. Questions are often the vehicle for this to take place, even when the questions are challenging our thinking or way of doing something.

**Find out what the patient already knows.** Don't assume ignorance. The only way to find out what a patient knows or has been thinking about is to ask. For example, most patients come into a medical setting having already talked to others about the reason for their visit. In fact, most patients come in having already formed an opinion about what is wrong with them and the best way to treat the problem. Asking is the safest strategy. *"What are your thoughts about what is wrong?"*

If we assume competence and experience, we can also assume expectations. So, a patient that transfers from one health care organization to another comes with a set of expectations. We often don't know anything about that prior experience. What we can assume, though, is that it has formed expectations and that our system is either conforming to those expectations or surprising the patient. When we are empowering patients, we seek out the information and make it useful in a dialog about how our approaches are similar and dissimilar to what the patient expects: *"Tell me about how you were used to getting appointments before."*

**Create choices.** Nothing is more empowering than creating options for and with patients and talking them through together. At times, we are able to simply give the patient the choice and it is not something that has to be a joint decision: *"We have openings on the morning of the sixth or the afternoon of the tenth. Which would you prefer?" "Do you want this prescription called in or would you rather take it with you now?" "Parking Lot A is usually pretty full, but if there is a space, it is closer to the entrance. B usually has spaces, but it is more of a hike."*

There may be options that we have not thought about. In fact, sometimes we may be stumped on how to solve a problem. The patient may have experience or thoughts about how to go about doing this that we have not considered. Again, asking is called for: *"What are your thoughts about how we might handle this?"*

Again, the more empowered the patient feels in his or her relationship to the health care team, the more positive the health outcomes.

## Summary

If we think of communication as a skill that affects health outcomes, and if we think of every member of the health care team as a participant in treatment whether one is directing traffic or sending out reminders of appointments, the emphasis on communication makes sense. Health care is different. The stakes are higher. And it calls for more sophisticated communication skills than many other arenas. For many people, it is a calling and not just a job.

Attitude, attitude, attitude. Patients, not perpetrators. How we think about communicating with patients is critical. Our thinking, though, is translated into what we do — how we listen and what we say. The C.A.R.E. framework was developed as a tool for thinking about communicating with patients and suggesting ways to communicate with them. 1) *Connecting* with them as people; 2) *appreciating* the situation in which they find themselves and letting them know we understand and are concerned; 3) *responding* to the problems they present and avoiding problems they might encounter; and 4) *empowering* them to work with us to address problems – these are all ways of increasing the effectiveness with which we communicate. Communication is often the most important means through which our patients know that we do care.