



Institute for  
Healthcare  
Communication

## **TREATING PATIENTS WITH C.A.R.E.**

**ANNOTATED BIBLIOGRAPHY**

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Angermeier I, Dunford BB, Boss AD, and Boss RW. (2009). The Impact of Participative Management Perceptions on Customer Service, Medical Errors, Burnout, and Turnover Intentions. *Journal of Healthcare Management*, 54:2, 127-141.

Numerous challenges confront managers in the healthcare industry, making it increasingly difficult for healthcare organizations to gain and sustain a competitive advantage. Contemporary management challenges in the industry have many different origins (e.g., economic, financial, clinical, and legal), but there is growing recognition that some of management's greatest problems have organizational roots. Thus, healthcare organizations must examine their personnel management strategies to ensure that they are optimized for fostering a highly committed and productive workforce. Drawing on a sample of 2,522 employees spread across 312 departments within a large U.S. healthcare organization, this article examines the impact of a *participative management* climate on four employee-level outcomes that represent some of the greatest challenges in the healthcare industry; customer service, medical errors, burnout, and turnover intentions.

This study provides clear evidence that employee perceptions of the extent to which their work climate is participative rather than authoritarian have important implications for critical work attitudes and behavior. Specifically, employees in highly participative work climates provided 14 percent better customer service, committed 26 percent fewer clinical errors, demonstrated 79 percent lower burnout, and felt 61 percent lower likelihood of leaving the organization than employees in more authoritarian work climates. These findings suggest that participative management initiatives have a significant impact on the commitment and productivity of individual employees, likely improving the patient care and effectiveness of healthcare organizations as a whole.

Bellon JS, Estevez-Cubilete A, Rodriguez N, Dandy R, Lane S, and Deringer E. (2010). Employee engagement and customer satisfaction. *Proceedings of the Academy of Health Care Management*, New Orleans, Volume 7, Number 1:1-5.

The focus of this paper is to examine how customer loyalty is impacted by employee satisfaction with their organizational culture in a health care setting. We analyze the influence that employee engagement and satisfaction have on customer loyalty. The firm's commitment to continuous improvement and the behavior of people in the organization toward their customers and each other are vital sources for firms to attain sustainable competitive advantage. In a world of increasing competition for consumer dollars, companies are realizing the need for employee engagement and belief in the organizations core values. A company's core values must be communicated to all employees and must be practiced by all leadership in order to insure buy in to the organizational culture. Organizational culture is translated to consumers by employees and this leads to loyal customers who will not only provide return business, but who will bring in new customers through word of mouth advertising. Since culture is shared by the group, people with an organization should perceive performance, control and behavioral norms similarly. Many studies have been done which show the benefit of employee engagement and how it affects customer loyalty. Without employee engagement, it is nearly impossible to connect with the consumer as the front line employees are the people that carry the organization's culture and value system to the consumers. If employees are engaged, they will project this to the consumer and customer loyalty will be the result.

Berry LL, and Leighton JA. (2004). Restoring customer confidence. *Marketing Health Services*,24(1): 14-19.

A service organization's most precious asset is its customers' confidence in the services it provides. But because customers are unable to “kick the tires” prior to purchasing a service, they need to have faith that the organization can and will deliver on its promise. Customers begin service experiences with some level of trust, but the quality of the delivered service determines whether the trust level rises or falls. The customers' confidence in the service is especially important in healthcare. In addition to being non-physical, healthcare services are complex (patients are at a steep knowledge disadvantage), inherently personal (no other service requires its customers to bare themselves as much emotionally and physically), and personally important (quality of life—and sometimes life itself—are at stake). Because healthcare is labor-intensive, skill-intensive, and equipment-intensive, it also is quite variable from one provider to another and one institution to another.

The core of healthcare marketing is strengthening the customer's confidence in the entity being marketed. Healthcare consumers need to feel confident in their providers, and they need the assurance that they're being cared for by the right people and the right organization. Any incidence of service failure puts the confidence of patients (or family members) at risk. Service recovery, therefore, is a critical concern of healthcare marketing. A fundamental aim of service recovery is to restore confidence that has been shaken. In other words, the customer's lost confidence is what is supposed to be recovered in service recovery.

Center on Wisconsin Strategy (2004). *Caring About Caregivers Reducing Turnover of Frontline Health Care Workers in South Central Wisconsin*, Madison, Wisconsin.

*Caring About Caregivers* focuses on frontline caregivers in nursing homes in the South Central Wisconsin region. This report is a follow-up to our 1999 report, *Improving Retention of Frontline Caregivers in Dane County*, extending the earlier investigation to a six-county area that includes Columbia, Dane, Dodge, Jefferson, Marquette, and Sauk Counties.

South Central Wisconsin is home to more than 10,000 frontline caregivers in nursing homes, home health agencies, and other sectors of the region's diverse and dynamic health care industry. In this report, we rely on data for the region's nursing homes to investigate the challenges and correlates of turnover among frontline caregivers.

Covey, S. R. (2001). Accelerated learning. *Incentive*, 175(2),16.

The author discusses the principle that follows “the best way to learn is through teaching” and recommends a training approach that follows this principle in the class room. He argues that the teaching technique gives learners a sense of the accelerated learning process. Dr Covey provides a review of the four advantages (for teachers and learners) for using the principle in the classroom:

Four advantages

1. You simply learn better when you teach. When you see yourself as a teacher, you take a far more responsible attitude toward learning. You are more motivated to learn when you know you are responsible to teach because the paradigm has shifted.

2. When you teach something you feel good about, you increase the likelihood of living it. Teaching creates a kind of social support system, a social expectation, or an implied social contract that you try to live.
3. When you teach what you learn, you promote bonding in the relationship. Every time you have an authentic teaching experience with another person and good comes from it that new learning experience causes teacher and student to become bonded. People who have been influenced by great teachers tend to feel very close to them.
4. When you teach something that you are learning, it hones the change and growth process for yourself. It makes change legitimate. You see yourself, (and others see you) in a new light; and when you begin to see yourself in a new light, you experience more and faster growth.

Dougherty CM. (2005). Customer Service in the Emergency Department. *Topic in Emergency Medicine*, 27(4)265-272.

Over the past few years, hospitals have determined to increase marketability in the rabid competition for healthcare dollars. Their efforts seem to be concentrated on offering services that customers can readily see and evaluate. For many hospitals and nurses, the means focusing on "hotel services." Customer service gurus have devised scripts and behaviors that hospital personnel are now being expected to adopt. For many patients, the only contact with a hospital may be a visit to the emergency department as a patient or family member of a patient. The emergency department becomes the portal through which customers decide if the care is satisfactory; the inpatient portion of the hospital must also provide satisfactory care. This presents a huge burden to emergency department nurses who must represent the whole of an institution. Many find themselves being asked to provide and concentrate on "hotel services," which customers can appreciate, and not on clinical care, of which the customer is often completely unaware. Many nurses find themselves with personal and ethical dilemmas in their attempt to help keep hospitals solvent and ensure job security and give excellent nursing care to the customers they formally thought of as patients.

Lane S, Posada C, Manzanero M, and Cohen S. (2009). Customer loyalty in healthcare. *Proceedings of the Academy of Health Care Management*, Las Vegas, Volume 6, Number 2:39-43.

Gaining customer loyalty requires a customer-focused attitude in the organization (Hawkins et. al, 2001). Customer loyalty depends on committed teams of employees and suppliers. To gain lifelong loyalty, an organization must continually meet and exceed customer expectations. The customer must believe that the organization is treating them fairly and is concerned with their overall well-being; therefore, customer service is of utmost importance. Customer service representatives are the front line troops in the battle to win the customer's loyalty. Loyalty can only be earned when leaders put the needs of their customers and their partners ahead of their own interests (Reichheld, 1996). In this paper we examine customer service and its importance in the health care field looking at both pharmaceuticals and hospital care. We find that there are differences in how organizations can develop customer loyalty in two branches of the health care field.

Lowe, S. (2009). Finding the right phrase to evoke the right response. *Emergency Nurse*, 16(9):8-9.

Healthcare professionals should examine therefore their own experiences of excellent customer service. Properly introducing themselves, acknowledging that people have been waiting, taking time to describe what is going on, explaining unexpected delays; these are all things that they welcome from others, but don't always demand of themselves or their colleagues. One answer is to develop written guidelines and train professionals to 'say things right'. Guidelines are common in all areas of clinical practice and should be welcomed as a way of improving the care that is given. It is sensible then to use them in the equally subtle area of patient communication.

McBride A, Hyde P, Young R, and Walshe K (2005). How the 'customer' influences the skills of the front-line worker. *Human Resource Management Journal*, 15(2):

Previous research illustrates how managers use the 'customer' in the *service* sector to develop roles and determine requisite skill sets. This article uses the evaluation of a recent workforce modernisation initiative in the NHS to provide insights into the manner in which the patient has played an increasing role in the construction of skills in *healthcare*. It indicates how public-funded *healthcare* in the NHS contains similar tensions and contradictions to *service* work in consumer capitalism. Although the patient is not in a position of authority, the desire of some workers to address fully the physical and psychological needs of the patient (or embodied *customer*) leads them to develop skills and roles that management may find hard to resource within current budgets.

Meier, D., & Corsini, S. (2001). 'The Accelerated Learning Handbook: Creative Guide to Designing and Delivering Faster, More Effective Training Programs. McGraw Hill, NY:NY.

A new game plan for training professionals comes in the form of Dave Meier's handbook on accelerated learning (AL), which more than fulfills its special promise as a springboard to practical and immediate action in the deployment of AL methods. His approach enables readers to apply his methods, and he gives us just enough of AL's philosophical underpinnings to make it work. Meier adds some fine examples of successful AL application from MetLife, 3M, Bell Atlantic, and other companies in keeping with the practical nature of the book.

Russell, L. (1999). *The Accelerated learning Fieldbook*. Jossey-Bass/Pfeiffer, San Francisco.

The Accelerated Learning Fieldbook provides tools to ensure that maximum learning and maximum retention are taking place in training sessions and classrooms. The author integrates theory and practical tools to enhance the learning experience. Each book chapter includes tools for personal and learning plan development.

Scotti, DJ, Harmon J, Behson SJ. (2007). Links Among High-Performance Work Environment, Service Quality, and Customer Satisfaction: An Extension to the Healthcare Sector. *Journal of Healthcare Management*, 52:2.

Healthcare managers must deliver high-quality patient services that generate highly satisfied and loyal customers. In this article, we examine how a high-involvement approach to the work environment of healthcare employees may lead to exceptional service quality, satisfied patients, and ultimately to loyal customers. Specifically, we investigate the chain of events through which high-performance work systems (HPWS) and customer orientation influence

employee and customer perceptions of service quality and patient satisfaction in a national sample of 113 Veterans Health Administration ambulatory care centers. We present a conceptual model for linking work environment to customer satisfaction and test this model using structural equations modeling. The results suggest that (1) HPWS is linked to employee perceptions of their ability to deliver high-quality customer service, both directly and through their perceptions of customer orientation; (2) employee perceptions of customer service are linked to customer perceptions of high-quality service; and (3) perceived service quality is linked with customer satisfaction. Theoretical and practical implications of our findings, including suggestions of how healthcare managers can implement changes to their work environments, are discussed.

Simkins, M. (2005). Accelerated learning. *Leadership*, 34(3), 24-33.

The article discusses the progress that has been made in closing the academic achievement gap between students of various racial and ethnic groups of the United States. After 20 years of being essentially stalled, progress is again being made toward closing the achievement gap. The bad news is: not everywhere, and not fast enough. According to a recent report by the U.S. Education Trust, most states are narrowing the gap, at least in reading and mathematics at the elementary grades, but the pace of improvement is too slow.

Steiger NJ, Balog A. (2010). Realizing patient-centered care: putting patients in the center, not the middle. *Front Health Serv Manage*, 26(4):15-25.

In these challenging times, healthcare executives must make difficult decisions when setting goals and allocating resources within their organizations. Patient-centered care means putting the patient in the center, not in the middle. Hospitals should view the world through the patient's and organize care around the patient. Investing in patient-centered care as an expression of mission, vision, and values is the right thing to do and has the potential to increase patient volumes and revenue. Realizing patient-centered care requires shared understanding, top leadership that can own and embrace the vision, engaged caregivers, and involved patients. There is an undeniable element of customer service in patient-centered care: Lessons from the retail industry can take us beyond merely meeting expectations to exceeding them.

Sugarman PA & Watkins J (2004). Balancing the scorecard: key performance indicators in a complex healthcare setting. *Clinician in Management*, 12: 129-32

Modern business management requires the effective monitoring of performance through systems such as the balanced scorecard. In complex healthcare settings, with specific customer and service characteristics, this can be difficult to implement. This paper sets out how performance indicators can be developed to truly capture complex clinical processes and to demonstrate performance improvement

Ward S; Blair M; Henton F; Jackson H; Landolt T; Mattson K. (2007). Educational innovations. Service-learning across an accelerated curriculum. *Journal of Nursing Education*, 46(9): 427-30

Abstract: In support of the community-based education philosophy, nursing faculty at a small health careers college in the Midwestern United States incorporated a service-learning experience involving Sudanese refugee families and Latino community members into its accelerated community-based nursing program (acE) curriculum. The purpose of the service-learning experience is to allow students the opportunity develop relationships through which

they may gain an understanding of unique needs within a community. This article describes the development and benefits of the service-learning experience across the acE curriculum. Through reflection, students broaden and deepen their understanding about the health of individuals in the community and acquire a more sophisticated understanding of risk factors associated with the social determinants of health. program faculty believe that having students involved in a continuous service-learning experience spanning the 15-month program allows students to develop strong relationships within the community and gain a greater understanding of the unique needs within that community. Overall, the experience has been successful and challenging.

### **Patient Satisfaction, Customer Service and C.A.R.E. principles**

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

**Abstract:** 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 proposed model are discussed. [Abstract from author]

**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.

Burgio, L. D., R. Allen-Burge, et al. (2001). "Come Talk With Me: Improving Communication Between Nursing Assistants and Nursing Home Residents During Care Routines." *Gerontologist* 41(4): 449-461.

**Abstract:** 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.

**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., B. 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.

Caris-Verhallen, W. M. C. M., A. Kerkstra, et al. (2000). "Effects of video interaction analysis training on nurse-patient communication in the care of the elderly." *Patient Education & Counseling* 39(1): 91-103.

Abstract: 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.

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., G. Uman, 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 healthcare 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. **Interventions:** None.

**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 healthcare 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 healthcare. 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.

Ford, W. S. Z. and O. J. Snyder (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.

**Abstract:** 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.

**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.

Hall, M. F. (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. [Abstract from Author]

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.

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

Objective: To examine patient, physician, and hospital administrator perceptions of quality in healthcare.

Design: Qualitative.

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

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.

Intervention: Focus groups.

Measures: Focus groups were conducted using the “Grounded Theory” procedural method. The interviews were recorded, transcribed, and coded.

Results: Eleven attributes of healthcare 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.

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

Abstract: Although US healthcare 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 healthcare from a service quality point of view. This illustration and a review of related literature from both inside and outside healthcare 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 healthcare, and physicians caring for patients can learn from them.

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

Abstract: 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.

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 healthcare providers for providing adequate, participatory health counseling and for understanding how to respond to patient concerns.

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.

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

Abstract: Assessed the communication skills (CS) of 25 healthcare 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. [Abstract from author]

Conclusions: In general, healthcare 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.

Ryan, E. B., J. M. Hamilton, 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.

Abstract: 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 nurturing 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.

**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 and Strasser S. (1993) "Service recovery in healthcare organizations." *Hospital & Health Services Administration* 38(1): 3-21.

**Abstract:** 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.

Shaw, C., Williams, Kate, Assassa, Philip R., Jackson, Clare (2000). "Patient satisfaction with urodynamics: a qualitative study." *Journal of Advanced Nursing* 32(6): 1356-1363.

**Abstract:** 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 gynecology, 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 healthcare 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.

Conclusions: Healthcare 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 healthcare providers to use appropriate language, neither too technical nor too patronizingly simple. Patient satisfaction was also improved when healthcare 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.

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 (i.e., time from triage until examination by the emergency physician and time from triage until discharge from the ED), information delivery (e.g., explanations of procedures and delays), expressive quality (e.g., 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.

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

**Abstract:** 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 analyzed 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.

**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, B. G. and J. R. Wilcox (2000). "Compliance Communication in Home Healthcare: A Mutually Reciprocal Process." *Qualitative Health Research* 10(1): 103-116.

**Abstract:** The study described in this article examined the process of compliance gaining in home healthcare. 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. [Abstract from author]

**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.