Behavioral Engagement with Pure Presence™
Webinar Series

Orientation Packet

with Georgianna Donadio, DC, MSc, PhD

Author of Changing Behavior: Immediately Transform Your Relationships with Easy to Learn Proven Communication Skills
Dear Health Professional:

The Behavioral Engagement with Pure Presence™ Webinar Series is designed to facilitate better communication skills for health care professionals. We are delighted you have chosen our webinar series to reach beyond standards of practice as you strive for greater personal growth and career success.

In today’s health environment, providers are challenged to manage their time while adhering to increasing regulatory, technological, and administrative requirements. Behavioral Engagement with Pure Presence™ is a product of 34 years of development and evidence-based research by the National Institute of Whole Health (NIWH) formulated to provide you with the skillset necessary to transform the patient-provider relationship, to increase the quality of service to your patients, and to improve the level of patient-provider satisfaction.

In preparation of your course, it is recommended you obtain and read the required course book prior to beginning your first workshop to receive the full benefit of this course offering. The bestselling book, Changing Behavior: Immediately Transform Your Relationships with Easy-to-Learn, Proven Communication Skills, can be obtained exclusively at Amazon.com in paperback or e-book editions. Throughout Changing Behavior you will find a multitude of evidence-based material which is referenced in the bibliography of the book for additional reading.

The videos provided throughout the workshop offer each learner an opportunity to explore how our own style of communication and relationship with ourselves impacts our relationships and communications with others. The videos in this workshop were presented and filmed at Tufts University School of Medicine, Tufts Medical Center.

We congratulate you on taking this important initiative to strengthen the patient-provider encounter! Enjoy taking a moment to learn important healthcare industry research regarding how and why this webinar will be a powerful tool for enhancing work with your patients or clients.

Best wishes,
Georgianna Donadio, DC, MSc, PhD
NIWH Program Director
Course Objectives

Develop a conceptual understanding of the Behavioral Engagement with Pure Presence™ Model.

Understand the importance of applying effective communication skills in today’s healthcare environment.

Describe how improving communication skills strengthens the patient-provider relationship leading to personal growth and increased opportunities for financial success.

Develop and utilize improved communication skills through application of the Behavioral Engagement with Pure Presence™ Model.
The National Institute of Whole Health
Whole Health Education Pilot Program

“Our clinic at the Lemuel Shattuck Hospital was for poor and chronically ill patients who wanted to deal with refractory pain conditions. They were a difficult patient population. Between 1980 and 1989, each year we placed at least one or two interns from NESWHE [now the National Institute of Whole Health] to perform health education counseling with our clients. These interns were always well educated, sensitive, willing to work hard and able to re-moralize and spark renewed interest in health and well-being in our difficult patients.”

“We came to rely on these placements because their enthusiasm for helping was a critical component of our clinical work to re-direct our patients towards a sense of self-help and self-reliance. On all levels, our relationships with NESWHE [now the National Institute of Whole Health] and its students was professional and of great value to our program.”

Ted Kaptchuk, OMD - Former Clinical Director
Lemuel Shattuck Hospital
Pain & Stress Relief Clinic Out-Patient Services
Jamaica Plain, MA
Pilot Study

Pilot Trial Study Evaluating Whole Health Education®
in Cardiac Rehabilitation Report 01/02

The Pilot Study set out to enroll 50 patients from the Cardiac Rehabilitation Department at Union Hospital. Patient population included a heart transplant recipient, patients with multiple pathologies, as well as obese, alcoholic, addictive and recalcitrant patients with varying cardiovascular disease. The patients were evaluated initially and at the end of six months using the SF36, a validated survey instrument widely used to measure quality of life. The evaluation also used a Clinical Data Collection Inventory (CDCI), which is a non-validated internal instrument.

In October 1997, the Union Hospital and the National Institute of Whole Health collaborated to carry out a pilot study of cardiac rehabilitation patients using Whole Health Education. The goal of the pilot study was to evaluate the effect of Whole Health Education on outcomes with cardiac rehabilitation patients.

Union Hospital is a 132 bed, community hospital located in Lynn, MA. Union Hospital is a part of The North Shore Medical Center and is a member of the Partners HealthCare System, founded by Massachusetts General Hospital and Brigham and Women's Hospital, both teaching hospitals of Harvard Medical School.

Whole Health Education is an invitational, non-directive model of health education, which empowers individuals to understand the cause and effects of their conditions through demystifying health information. The development of Whole Health Education® began in 1977 by Dr. Georgianna Donadio, founder and director of the National Institute of Whole Health Education, (NIWH), Boston, MA. NIWH trains educators in providing "Health Education for the Whole Person." Whole Health Education is a peer-counseling model of patient health education based on respectful listening, a whole picture of health® perspective, transformative behavioral engagement skills and personalized health information research.
The Pilot Study, initiated in 1997, set out to enroll 50 patients from the Cardiac Rehabilitation Department at Union Hospital. Patient population included a heart transplant recipient, patients with multiple pathologies, as well as, obese, alcoholic, addictive and recalcitrant patients with varying cardiovascular disease. The patients were evaluated initially and at the end of six months using the SF36, a validated survey instrument widely used to measure quality of life. The evaluation also used a Clinical Data Collection Inventory (CDCI), which is a non-validated internal instrument.

Patients were contacted via letter by the Pilot Study Coordinator, Anna Seubert, and those expressing interest were contacted by the Study Coordinator who outlined the study protocol. If patients agreed to participate, they completed the SF36 and the CDCI. They then met with a Whole Health Educator for six, one-on-one sessions. Patients then completed another SF36 and CDCI six months later.

The data from the Whole Health Education patients was compared with data from historical controls. These were patients who had only been through cardiac rehabilitation. The control patients had filled out baseline and six month SF36 and CDCI questionnaires. The control group was not studied at the same time as the treatment group, and no attempt at randomization was made. No attempt was made to pair subjects, and the study was not considered a controlled study. The study was approved by the Investigational Review Board at Union Hospital.

Patients in the Whole Health Education application component of the study were enrolled in 1998 and 1999. Six certified Whole Health Educators and six Interns from the National Institute of Whole Health participated in educating the patients in the study at Union Hospital. The study was funded in part by Union Hospital and in part by the National Institute of Whole Health.

Anna Seubert, the coordinator for The Pilot Study, has been an educator for more than twenty-five years and has worked with communities and individuals in building bridges between complimentary and conventional health care. Anna had been working with the Healing Connection at Union Hospital prior to the Pilot Study.

The Principal Investigator for the Pilot Study was Harvey Zarren, MD, FACC, a cardiologist in private practice and also Medical Director of the Department of Cardiac Rehabilitation at Union Hospital.
OUTCOMES

The Study was not powered to reach statistical data significance. The sample size was small and the SF36 and CDCI may not have been optimal indicators of the experiences of the patients.

Although no significant overall clinical differences were observed between the treatment group and the control group in SF36 data or in CDCI data, there were quality of life questions where patients receiving Whole Health Education did significantly better than the control group after 6 months. The Questions involved:

· Sharing feelings routinely, --> 11% improvement  
· Level of stress, --> 6% improvement  
· Perceptions of tendency to get sick compared to others, --> 22% improvement  
· Expectations of future health decline, --> 21% improvement  
· Perceptions of current health status. --> 4% improvement

PATIENT ANECDOTES
at their 6 -12 month follow-ups

For representations of the Whole Health Education experience, the best indicators are patients' anecdotal comments. Many patients who experienced Whole Health Education said

"No one has ever listened to me in such a deep, respectful fashion before."

Other comments from Whole Health Education patients included:

"The effects of this process have been very subtle but life-changing for me."

"I am choosing to do things for myself that I have not thought about in a long time."

"I finally have information that's helping me to make different kinds of choices."

"Never before in my life have I been listened to like this!"

"Thanks to following your program I am a completely new man."

"I have a new approach to life including a change in eating habits, stress reduction, and improved physical health. I have made new friends and have fun socially. This has been a real plus in my life."

"I have more knowledge of mitigating diet factors and habits for general health and control."

"I have more information on what and what not to do."
"I got enlightenment."

"I've become stronger, got education for self-care and got support from wonderful people who worked with me."

"I got information on the latest nutritional findings and recommendations about vitamin do's and don'ts and exercise information to improve my heart and general health."

"I got health!"

"I got to educate myself about diet, exercise, and change of lifestyle to reduce my risk of heart surgery."

"I've become more energetic and I've felt much better after the program."

"I have a firmer grip on understanding not only the outside forces that affect my health and hopefully ways to deflect or better manage these influences."

"I got muscle tone and friendship with people."

"I learned more about my body and its function and diet control and effects."

"I got a healthier heart."

"Thank you for your help, support and education. All of you gave me on a day to day basis peace and compassion: the most important pill. Good health and happiness to you and thank you."

"I received knowledge of my body, ways to extend my life, and to live healthier."

"I learned to feel good about myself and to enjoy life to the fullest."

"I received knowledge of my ailment, treatments available and strengthening of my heart and body."

"I learned why it's important to exercise and eat correctly. Just to know there are other people like me is consoling."

"I learned about a healthy heart, body and mind."

"I learned to help myself with a spiritual program and meditation."

"I know a few of the guys in rehab wished they had had the chance to work with the Whole Health Educators."

"I received a better understanding of myself."
SUMMARY

The Pilot Study demonstrated that Whole Health Education was not only valuable but also desirable in the journey of cardiac patients towards wellness. The qualitative data, collected in the form of exit interviews with patients, interviews with staff, and unsolicited notes and letters was positive. Patients who had presented with behavior problems for staff became cooperative and related in a manner serving themselves and others in a much better fashion.

The Whole Health Educators had a lot of time with patients: time that patients valued in itself, apart from any informational content. That time was effective in allowing patients to see their conditions more clearly and to work through barriers to improved health.

The relationship of Educators to patients provided behavior models that, along with the education content, allowed for persistent lifestyle changes. The combination of Cardiac Rehabilitation and Whole Health Education allowed repetitive exposure of patients to information enabling them to make better decisions about behaviors creating wellness.

The Principal Investigator for the Pilot Study, Dr. Harvey Zarren said "As a physician, I find that Whole Health Educators are incredibly supportive in my attempt to help patients regain or maintain wellness.

The Educators reinforce knowledge, motivate patient behavior, and have the time to help remove barriers to wellness. Whole Health Education is a very potent, valuable tool in helping patients transform their lives. Whole Health Education can be a very effective ally in the health care practitioner's efforts on behalf of patients."
Other findings associated with the study and application of Whole Health Education:

Excerpted from Report by Harvey Zarren, M.D., F.A.C.C.

January, 2001

"Whole Health Education is a model of patient education that allows relationship skill building in an overt way. It is totally supportive, not expensive, and incredibly effective. It invites people to learn rather than directing them as to what to do. It values participation and useful behavior rather than moralizing about a particular course of action. It is a model for all relationships. Here is a method of education that can help to transform medical care for both patients and caregivers, allowing the healing experience to once more be a journey towards wellness for all.

Whole Health Education at Union Hospital [is] in service to patients, health care professionals and health care itself. The pilot program demonstrated clearly that Whole Health Education was not only valuable but also desirable in the journey of patients towards wellness. Every patient said "No one has ever listened to me with such respect and attention." Patients who presented behavior problems for staff became cooperative, and related in a manner serving everyone in a much better fashion [and] allowed patients to see their condition more clearly and to work out barriers to health improvement. The relationship of educator with patient gave people a behavior model that, with the content of the education, allowed for persistent lifestyle changes.

Other patients, with behavior problems such as alcohol abuse have been exposed to Whole Health Education at the hospital. In each case, the invitational, respectful attitude of the educators has been instrumental in patient behavior changes leading towards wellness.”

Harvey Zarren, MD, FACC
Medical Director
Department of Cardiac Rehabilitation
Union Hospital
Impact of Communication in Healthcare

“Extensive research has shown that no matter how knowledgeable a clinician might be, if he or she is not able to open good communication with the patient, he or she may be of no help.”

Introduction

Research evidence indicates that there are strong positive relationships between a healthcare team member’s communication skills and a patient’s capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies conducted during the past three decades show that the clinician’s ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care.

Background

Patients’ perceptions of the quality of the healthcare they received are highly dependent on the quality of their interactions with their healthcare clinician and team. There is a wealth of research data that supports the benefits of effective communication and health outcomes for patients and healthcare teams. The connection that a patient feels with his or her clinician can ultimately improve their health mediated through participation in their care, adherence to treatment, and patient self-management.

Yet, it is estimated that one-third of adults with chronic illnesses underused their prescription medication due to cost concerns; yet they fail to communicate this information to their physician. Another study found that less than half of hospitalized patients could identify their diagnoses or the names of their medication(s) at discharge, an indication of ineffective communication with their physicians.

The Institute of Medicine (IOM) Report on Health Professions and Training has identified that doctors and other health professionals lack adequate training in providing high quality healthcare to patients. The IOM called upon educators and licensing organizations to strengthen health professional training requirements in the delivery of patient-centered care.
The patient-centered care model\textsuperscript{13} underscores the essential features of healthcare communication which relies heavily on core communication skills, such as open-ended inquiry, reflective listening, and empathy, as a way to respond to the unique needs, values, and preferences of individual patients\textsuperscript{14}.

**Healthcare Communication Outcomes**

A clinician may conduct as many as 150,000 patient interviews during a typical career. If viewed as a healthcare procedure, the patient interview is the most commonly used procedure that the clinician will employ. Yet communication training for clinicians and other healthcare professionals historically has received far less attention throughout the training process than have other clinical tasks.

This is so even as evidence continues to mount that a structured approach to communication measurably improves healthcare delivery.

**Diagnostic Accuracy**

\begin{itemize}
\item Most diagnostic decisions come from the history-taking component of the interview\textsuperscript{15}. Yet, studies of clinician-patient visits reveal that patients are often not provided the opportunity or time to tell their story/history, often due to interruptions, which compromise diagnostic accuracy. Incomplete stories/history leads to incomplete data upon which clinical decisions are made.
\item When interruptions occur, the patient may perceive that what they are saying is not important and leads to patients being reticent to offer additional information.
\item The bottom line is that when patients are interrupted, it is a deterrent to collecting essential information and it hinders the relationship.
\end{itemize}

**Adherence**

\begin{itemize}
\item Adherence is defined as the extent to which a patient’s behavior corresponds with agreed upon recommendations from a healthcare provider\textsuperscript{16}. Certainly, we are all aware of the huge problem of non-adherence in healthcare. For instance, a Health Care Quality Survey\textsuperscript{17} conducted by the Commonwealth Fund found that 25% of Americans report they did not follow their clinician’s advice and provides the reasons cited in this survey:
\begin{enumerate}
\item \textbf{39%} disagreed with what the clinician wanted to do (in terms of recommended treatment)
\item \textbf{27%} were concerned about cost
\item \textbf{25%} found the instructions too difficult to follow
\item \textbf{20%} felt it was against their personal beliefs
\item And \textbf{7%} reported they did not understand what they were suppose to do
\end{enumerate}
\end{itemize}
**Patient Satisfaction**
The core elements comprising patient satisfaction include:

- **Expectations:** Providing an opportunity for the patient to tell their story.

- **Communication:** Patient satisfaction increased when members of the healthcare team took the problem seriously, explained information clearly, and tried to understand the patient’s experience, and provided viable options.

- **Control:** Patient satisfaction is improved when patients are encouraged to express their ideas, concerns and expectations.

- **Decision-making:** Patient satisfaction increased when the importance of their social and mental functioning as much as their physical functioning was acknowledged.

- **Time spent:** Patient satisfaction rates improved as the length of the healthcare visit increases.

- **Clinical team:** Although it is clear that the patient first concern is their clinician, they also value the team for which the clinician works.

- **Referrals:** Patient satisfaction increases when their healthcare team initiates referrals relieving the patient of this responsibility.

- **Continuity of care:** Patient satisfaction increases when they receive continuing care from the same healthcare provider(s).

- **Dignity:** As expected, patients who are treated with respect and who are invited to partner in their healthcare decisions report greater satisfaction.

**Patient Safety**

- An estimated one-third of adverse events are attributed to human error and system errors.

- Research conducted during the 10 year period of 1995-2005 has demonstrated that ineffective team communication is the root cause for nearly 66 percent of all medical errors during that period.

- This means that when health care team members do not communicate effectively, patient care often suffers.

- Further, medical error vulnerability is increased when healthcare team members are under stress, are in high-task situations, and when they are not communicating clearly or effectively.
Team Satisfaction
Why is Team satisfaction important?

- Communication among healthcare team members influences the quality of working relationships, job satisfaction and profound impacts patient safety. 

- When communication about tasks and responsibilities are done well, research evidence has shown significant reduction in nurse turnover and improved job satisfaction because it facilitates a culture of mutual support.

- Larson and Yao found a direct relationship between clinicians’ level of satisfaction and their ability to build rapport and express care and warmth with patients.

What are the elements that contribute to healthcare team satisfaction: Feeling supported, e.g., administratively and inter-personally, respected, valued, understood, listened to, having a clear understanding of role, work equity and fair compensation.

Malpractice Risk

- According to Huntington and Kuhn, the “root cause” of malpractice claims is a breakdown in communication between physician and patient.

- Previous research examined plaintiff depositions found that 71% of the malpractice claims were initiated as a result of a physician-patient relationship problem. Closer inspection found that most litigious patients perceived their physician as uncaring. The same researchers found that one out of four plaintiffs in malpractice cases reported poor delivery of medical information, with 13% citing poor listening on the part of the physician.

Summary

Research evidence indicates that there are strong positive relationships between a healthcare team member’s communication skills and a patient’s capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies show that the clinician’s ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. Further, communication among healthcare team members influences the quality of working relationships, job satisfaction and has a profound impact on patient safety.

Clinicians and other members of the healthcare team conduct thousands of patient interactions during their career. The call to action from the Institute of Medicine (IOM) Report on Health Professions and Training underscores the importance of communication training for clinicians and members of the healthcare team. Similar to other healthcare procedures, communication skills can be learned and improved upon. Improvement in communication skills requires commitment and practice.
Given the wealth of evidence linking ineffective clinician-patient communication with increased malpractice risk, nonadherence, patient and clinician dissatisfaction, and poor patient health outcomes, the necessity of addressing communication skill deficits is of the utmost importance.

References


Preparing a health care workforce for the 21st century

THE CHALLENGE OF CHRONIC CONDITIONS

World Health Organization
Noncommunicable Diseases and Mental Health Cluster
Chronic Diseases and Health Promotion Department
TABLE 1: CORE COMPETENCIES DESCRIBED IN THIS PUBLICATION

1. Patient-centred care
   - Interviewing and communicating effectively
   - Assisting changes in health-related behaviours
   - Supporting self-management
   - Using a proactive approach

2. Partnering
   - Partnering with patients
   - Partnering with other providers
   - Partnering with communities

3. Quality improvement
   - Measuring care delivery and outcomes
   - Learning and adapting to change
   - Translating evidence into practice

4. Information and communication technology
   - Designing and using patient registries
   - Using computer technologies
   - Communicating with partners

5. Public health perspective
   - Providing population-based care
   - Systems thinking
   - Working across the care continuum
   - Working in primary health care-led systems

These core competencies have the potential to shift current thinking about providing care for patients with ongoing health problems and, in turn, to reform the training and preparation of the health care workforce. The five competencies do not replicate or preclude established core competencies (2, 4, 24–25). Rather, these core competencies augment existing knowledge and skills to provide better care for patients living with chronic
Conclusions

The transition from acute to chronic health problems places a new and different set of demands on the health care workforce. In addition to skills that facilitate the diagnosis and treatment of acute illness and injury, today’s workforce needs a core set of competencies that will yield better outcomes for patients with chronic conditions. A workforce for the 21st century must emphasize management over cure, and long-term over episodic care.

This document identifies a core set of competencies to improve care for chronic conditions:

- The essence of this care is to centre on the patient. This is a shift from traditional, provider-focused practice, and it requires the workforce to develop communication skills that empower patients through seeing health from the patient’s perspective, and motivating and training patients in health-related self-management.
- Solo practice is no longer adequate to achieve positive outcomes for chronic problems; the workforce must be capable of creating and maintaining partnerships with everyone involved: patients and their families, other providers and the community.
- The workforce needs skills that ensure continuous quality improvement in terms of patient safety and service delivery efficiency.
• The ability to use available *information and communication technology* is essential in caring for patients with problems that persist across time, providers and settings.

• Finally, the workforce needs the ability to view health care from a broad, *public health perspective*, which will enable them to understand their responsibility and accountability within the larger health care system.

The health care workforce is among the most important factors in the health care system. They are instrumental in stimulating, implementing, and maintaining change to improve care for chronic conditions. Consequently, educational reform for this group is essential. Improvements in their preparation and training will require the commitment of a broad-based partnership. Genuine educational reform will not be possible without concerted and sustained efforts among decision-makers, academic leaders and health-related professional bodies.
Successful Communication Techniques and Practices
By Joy Hicks

With planning and care, the office manager can increase efficiency and effectiveness exponentially through successful communication techniques and practice. Communication is one of the most important tools in any relationship, be it personal or professional. In order for communication to be completed, there must be ideas or information to be shared, someone to give the information or idea, and someone who will receive the information.

Communication is best when it is reciprocal, meaning that ideas and information are shared between the two with each giving and taking from the exchange. When communication is one sided, the possibility of miscommunication or misunderstanding is high and these lead to unmet expectations and poor results. In a relationship, most often we go back and apologize for any misunderstanding and try again, but in a medical office, miscommunication can be costly both physically and financially. Studies among the most effective leaders show that communication is the most important skill a manager or leader can possess and use.

So, what does effective communication look like in the medical office setting? To communicate most effectively clear and concise information is crucial. Whether in a memo, a written communication, through an inner office email, one on one interaction, or in a group setting, it is important to stick to the topic at hand and not stray off point. Using the 5 W's and an H approach of journalism will help to keep the focus on the issue:

**Who:** Who needs the information being shared? Who will this information affect? Who is or will be accountable?

**What:** What steps need to be taken? What outcome is desired? What resources are needed to complete the process or project? What are the circumstances directly affecting this matter?

**Why:** Why is this important? Why is the person receiving this information included?

**Where:** Where will the event, meeting, work take place? Where are the materials or data needed to complete the project?

**When:** When is the meeting? When is the deadline? When is feedback or progress requested?

**How:** How will success be measured? How will performance be evaluated? How will completion be certain?
These are just a few questions that might be addressed to keep the information clear and concise. Another good rule of thumb when addressing others is: "Say what you mean, and mean what you say." When others know that you give meaningful information and feedback, they are more likely to listen intently and regard your exchange with respect.

A manager who gossips, chatters incessantly about non-business matters, or strays off topic during meetings will be less effective because their employees will begin to tune out the “fluff”. While it is important to have a working rapport with your coworkers and employees, it is equally important to have professional awareness.

Feedback is another important part of effective communication. Listening to feedback will assist all parties in understanding. A technique called “active listening” is a helpful tool to ensure that understanding is complete. In this technique the listener will rephrase the information they heard in their own words. If this information is correct, the exchange is complete, if not the sender of the information can correct any misunderstandings at this time. This exchange takes only a little more time and is an efficient tool for creating accountability because everyone involved in the exchange knows that expectations were clear and understood.

Clear and effective communication saves time, money, and aggravation. When all parties understand what is needed, expected, and acceptable, progress is more certain. When all parties understand why something is necessary, they feel respected. When ideas are exchanged and feedback is considered, all parties feel included and important to the process. These feelings of inclusion and importance are crucial to office morale and overall success of the practice.
Communication gaffes: a root cause of malpractice claims
Beth Huntington, BSN, MSN, JD¹ and Nettie Kuhn, RN, BSPA, CPHRM¹

We are presently in the throes of another medical malpractice insurance crisis, not unlike the crisis that occurred in the late 1970s. The availability of medical malpractice insurance is diminishing; insurance premiums are skyrocketing; insurance carriers are going bankrupt or refusing to write insurance policies in Texas. In some areas, the cost of malpractice insurance is prohibitive, causing physicians to leave medicine. The most concerning fallout is that patient access to care is being compromised.

It is easy to blame insurance companies, plaintiff lawyers, and runaway juries for our woes. It is harder to examine our own practices and ask ourselves what we could do to change patients' feelings that they need to sue doctors, hospitals, and nurses. In this age of phenomenal technological innovations and highly successful treatments and cures, why is it that our customers, the patients, are dissatisfied with their health care to such a degree that they feel compelled to file a lawsuit?

Several papers have been published that address this question (1–3). The authors of these studies utilized different study techniques to tap into the mindset of the patient/plaintiff. In one study, deposition transcripts were reviewed (3). Another team used questionnaires to survey plaintiffs (2), and the third conducted their study by telephone survey. In all 3 studies, common themes emerged. The 4 predominant reasons prompting patients to file a lawsuit included 1) a desire to prevent a similar (bad) incident from happening again; 2) a need for an explanation as to how and why an injury happened; 3) a desire for financial compensation to make up for actual losses, pain, and suffering or to provide future care for the injured patient; and 4) a desire to hold doctors accountable for their actions.

Overwhelmingly, the dominant theme in these studies' findings was a breakdown in the patient-physician relationship, most often manifested as unsatisfactory patient-physician communication. Study participants described the perceived communication problems as follows: physicians would not listen, would not talk openly, attempted to mislead them, or did not warn them of long-term neurodevelopmental problems (in the case of newborn
injury). Other communication problems cited included perceptions that doctors deserted patients or were otherwise unavailable, devalued patient or family views, delivered information poorly, or failed to understand the patient’s perspective.

Clearly, these studies underscore the well-known principle that good communication is the cornerstone of the physician-patient relationship. As the authors have often observed, and as is well documented in the literature, patients are not likely to sue physicians with whom they have developed a trusting and mutually respectful relationship. Simply put, patients do not sue doctors they like and trust. This observation tends to hold true even when patients have experienced considerable injury as a result of a “medical mistake” or misjudgment.

Do physicians have influence over the circumstances that cause patients to file lawsuits? While physicians cannot control all the stated reasons for patients' seeking legal redress, they are able to influence the quality of their relationships with patients. And, as already noted, the foundation for a good patient-physician relationship is communication. This article discusses the “art” of communication as it occurs in everyday patient encounters, the important dialogue that occurs when giving informed consent, the challenge of encountering an angry patient, and the new trend of disclosing unexpected outcomes and medical errors.

Go to:

THE “ART” OF PATIENT-PHYSICIAN COMMUNICATION

The American Association of Orthopedic Surgeons (AAOS) strongly endorsed the communication aspect of the patient-physician relationship in its advisory statement “The Importance of Good Communication in the Physician-Patient Relationship” (4). In that statement, the AAOS described patient-focused communication as open, honest dialogue that builds trust and promotes healing. Taking it a step further, the AAOS commented that good communication has a favorable impact on patient behavior, patient care outcomes, and patient satisfaction; as a consequence, it often reduces the incidence of malpractice lawsuits.

According to the AAOS, physicians who practice patient-focused communication show empathy and respect, listen attentively, elicit patients’ concerns and calm fears, answer questions honestly, inform and educate patients about treatment options, involve patients in medical care decisions, and demonstrate sensitivity to patients' cultural and ethnic diversity (4).

The importance of developing rapport with patients cannot be overemphasized. Effective communication skills are a critical tool that assists the physician in establishing that optimal patient rapport. Physicians need to keep in mind that today's health care consumers, particularly those in the baby boomer and younger age groups, have much more medical knowledge than senior citizens. Both young and old, however, often judge the quality of care received on the basis of the physician-patient interaction. Certainly, the physician's skill and reputation play an important role in a patient’s confidence. However, many if not most patients assume that physicians have the requisite technical skill to treat their medical problems. From the patient’s perspective, therefore, what separates the adequate or average physician from the truly great physician is how well the physician practices the “art” of medical care, conveying those highly valued human skills of compassion and caring concern that patients seem to need so much.
All too often, when physicians do not communicate caring concern, especially when the care is painful, difficult, or results in less-than-optimal outcomes, an inevitable cycle of miscommunication occurs among patient, family, and physician. Under these circumstances, patients who express their anger and frustration may cause the physician to react defensively in a way that may be perceived as hostile or arrogant. Most often it is this response that causes the patient to seek the advice of an attorney, because poor communication between a physician and patient can lead an already angry, dissatisfied patient to believe the care was poor even when it was entirely appropriate (5). In the arena of physician liability, the burden of “successful” patient-physician communication lies with physicians (5). That is not to say that patients do not share the burden, but society and the courts have deemed that physicians have the ultimate responsibility for initiating, clarifying, facilitating, documenting, and reinforcing discussions related to their patients' condition, treatment, and prognosis (5).

An often-cited study published in the February 19, 1997, issue of the Journal of the American Medical Association illustrates these points (6). The purpose of the study was to identify specific communication behaviors that were associated with an increased frequency of malpractice claims. The authors collected data by videotaping routine office visits of 59 primary care physicians and 65 general and orthopedic surgeons and studying 10 tapes per physician. Interestingly, the researchers found no difference in communication behaviors between surgeons who experienced malpractice suits and those who did not. However, significant differences in communication behaviors were identified between primary care physicians who experienced no malpractice claims and those who were sued. The critical communication behaviors that differentiated the “no claims” from the “claims” primary care physicians were the following: 1) greater use of orientation statements that served to educate patients on what to expect, 2) greater use of laughter and humor, and 3) greater tendency to solicit patients’ opinions, check their understanding, and encourage them to talk. What this all boils down to is that the physicians who had no claims established better rapport with their patients and evoked greater patient satisfaction.

Communication is something we all take for granted, which is why we don’t consciously think about our communication habits and behaviors. For many, conscious awareness of one's communication habits requires considerable work and energy. And yet, it is the little things that can make such a difference. For example, the opening of the medical encounter sets the stage for a trusting and caring relationship when the patient is invited to share his feelings and concerns. A crucial point in the encounter is the physician’s first greeting of the patient. Does the physician show personal concern by offering a handshake and a warm smile? This action instantly puts the patient at ease in what could otherwise be an unfamiliar, if not frightening, environment. An explanation of the agenda for the visit sets the patient’s expectations and aligns them with the physician’s. Maintaining eye contact rather than staring off into space, out the window, or at notes indicates that the physician cares about the patient. Additionally, maintaining eye contact cues the physician on the patient’s reactions as conveyed by body positioning, eye movement, or other body language. The body language of the physician is also a powerful communicator of attentiveness to what the patient is saying. A sitting position demonstrates an interest and an unhurried attitude, while a standing position may give the impression of control, an authoritative attitude, and being rushed.

The bottom line is this: patients who enjoy a positive therapeutic rapport with their physicians do so because mutual expectations are in line and there is good communication
flow from patient to physician and physician to patient. The key ingredient is that the patient is left with the strong sense that the physician cares about the care being given and the person to whom the care is rendered. A model developed by the Bayer Institute for Health Care Communication illustrates this dynamic well. The “4E” model uses the approach of engage, empathize, educate, and enlist for obtaining information and furthering the relationship (7). All these elements of communication are important to enhancing patient satisfaction and minimizing the desire to resolve problems through contentious lawsuits.

**THE IMPORTANT TASK OF ALIGNING EXPECTATIONS**

Today's patients, especially the younger generation, want to be involved in making decisions about their health care. Patients want to be told the treatment options available and why a particular option is recommended. Much has been written about the therapeutic effects of full informed consent. The very act of disclosure lessens patients' anxiety, increases their trust in the physician, often results in a smooth clinical course, improves patient understanding, and decreases the unpleasant “surprise factor” should anything go awry. This process allows time to dispel any unrealistic expectations before the treatment begins. The objective of informed consent should be to replace some of the patient's anxiety by providing a sense of participation in and control over his or her care. Obviously, this cannot occur if the informed consent process consists merely of handing the patient a piece of paper to sign. A golden opportunity to enhance patient-physician rapport is lost if the physician does not take time to go through all the elements of consent, which include explaining the procedure along with the specific risks, possible complications, and alternate treatments available.

Remember that the informed consent process is the physician's opportunity to allay patient anxiety, bridge the gap between patient ignorance and supposed physician omnipotence, and dispel uncertainty. This is one of those moments in the patient-physician relationship when the patient is most vulnerable. Thus, it is important to prepare patients without sabotaging their confidence. For example, compare these 2 statements:

- Here is a list of complications that could occur during your operation. Please read the list carefully and sign it. If you don't understand something, ask me.
- I wish I could guarantee that there will be no problems during your operation, but that wouldn't be realistic. Sometimes there are problems that cannot be foreseen, and you need to know about them. Please read about them, and let’s talk about it.

The second statement is the better option. It lets the patient know that the physician is not omnipotent, that the patient and the physician are facing some degree of uncertainty together, and by implication both are going to cooperate in doing something to the patient's body that will make him or her better. But there are no guarantees as to how the patient's body will respond.

Some physicians try too hard to reassure patients. In some instances the reassurance may be overreaching, and unintentionally the physician creates unwarranted expectations. Compare the following statements:
Don't worry about a thing. I've taken care of a hundred cases like yours. You will do fine.
Barring any unforeseen problems, I see no reason why you shouldn't do very well. I'll certainly do everything I can to help you.

The second statement establishes more realistic patient expectations while at the same time remaining reassuring.

ENCOUNTERS WITH THE ANGRY PATIENT

Few encounters are more challenging than confronting the angry patient. The patient who is angry—with his doctor, about the care he is or is not receiving, or about an outcome of care—is a lawsuit waiting to happen. The physician, not the lawyer, is in the best position to defuse the patient's anger (8).

Remember, anger is the way people respond to unmet needs or expectations. Most of the time the anger (rightly or wrongly) is directed toward the physician because he or she is the most convenient and visible target. One of the worst mistakes a physician can make when dealing with angry patients or families is to avoid them. While this is an understandable reaction, it is also the surest way to hasten the patient's visit to the attorney's office. As difficult and unpleasant as it may be, the most effective way to defuse anger is to listen, empathize, and apologize that things did not turn out the way the patient expected or hoped.

When faced with someone who is upset or angry, it may be prudent to remain silent and allow that person to talk about the problem. Any person confronted by an angry, complaining patient is likely to feel personally affronted. In those moments, one's natural tendency is to become defensive or hostile. This is especially true when the complaint is unwarranted. While the easiest and most natural reaction is to strike back, the better practice is to avoid fighting words, listen without interruption, avoid becoming defensive, express empathy, ask questions, determine what the patient wants, explain what can and cannot be done, and discuss alternatives.

DISCLOSING MEDICAL ERRORS

One of the most difficult aspects of medical practice is dealing with adverse outcomes. A complication that occurs during medical care or treatment is distressing to the physician, the patient, and the patient's family. When the patient experiences an adverse outcome, it is always better to have a forthright conversation with the patient, explaining what happened and why. The best reason for disclosure is that it is the one sure way of assuring that the patient will continue to trust the physician. Nothing defuses patient anger better and faster than a sympathetic, open-minded physician who is willing to discuss not just the successful outcomes of care but the glitches and problems that arise as well. Studies have shown that what patients want from their physicians following an error is an apology and the assurance that what happened to them will not happen to someone else (2).

Since publication of the Institute of Medicine report *To Err is Human*, consumers have become more aware of errors and problems associated with health care. The news media's
coverage of medical errors at that time created a public call for change. The Joint Commission on Accreditation of Healthcare Organizations responded by issuing patient safety standards that require health care providers to inform patients about “unanticipated outcomes.” What could be more challenging to physicians than disclosing unanticipated outcomes, especially those that may have resulted from medical errors?

Despite this directive to the health care industry, physicians and nurses are fearful and reluctant to disclose. This is understandable if the provider believes that admitting mistakes is not safe and may cause patients to file lawsuits. The question is, are these assumptions valid? Not every error is the result of negligent behavior. Consider this example: it is not necessarily negligent to perforate the bowel during an endoscopic procedure. What might be considered to be below the standard of care would be the physician’s failure to do any of the following:

- Explain this potential complication to the patient as part of the informed consent
- Describe to the patient symptoms to be aware of after the procedure that might indicate that a complication has occurred
- Tell the patient a perforation did occur
- Recognize the complication in a timely manner (9)

Maithel stated, “The principal argument in favor of disclosing medical errors to patients is based on the ethical duty that physicians have to patients. Physician-patient relationships are based on a bond of trust that develops when one person relies upon another's judgment for his or her well-being. Physicians are required to act in the best interests of the patient, putting aside one's own interests” (9).

Note that the professional medical groups also address the physician’s responsibility to disclose errors to patients. The American College of Physicians, in its Ethics Manual, recommends that “physicians should disclose to patients information about procedural or judgment errors made in the course of care if such information is material to the patient’s well-being. Errors do not necessarily constitute improper, negligent or unethical behavior, but failure to do so [disclose errors] may.” The American Medical Association, through its Council on Ethical and Judicial Affairs, issued an opinion holding that physicians should disclose to patients mistakes that result in significant medical complications. The opinion states, “Concern regarding legal liability which might result following truthful disclosure should not affect the physician’s honesty with a patient.”

Fear of litigation is frequently cited as the reason not to disclose errors, but studies show that this fear is largely exaggerated (9). Malpractice litigation is not nearly as prevalent as physicians think. At least 4 major studies have found that only 1% to 2% of negligent adverse events led to actual claims (10–13).

Most patients who experience iatrogenic injuries or are dissatisfied with their care ignore the problem or find other ways to resolve the problem, including changing physicians (14, 15). Physicians overestimate their risk of being sued by about 3 times the actual rate (16).

On the flip side, several studies have shown that failure to be honest with patients is a frequent cause of litigation. Witman et al found that patients were significantly more likely to sue if the physician did not disclose an error (17). In another study, researchers found that patients' decision to sue was influenced not only by the original injury but also by
Insensitive handling and poor communication afterward (2). Patients were more likely to sue when they believed there was a “cover-up” of information or when they wanted more information and the only way they could get it was to file a lawsuit. Note the common theme that seems to trigger litigation: uncertainty. Patients are uncertain about what happened and how. Patients are uncertain that they were given all the information that was available (18). Note the absence of fault finding. Patients do not seem to be suing because of a perception that their physician was at fault for their outcome. The authors have observed that patients are more willing to “forgive” the humanness of physicians when a mistake is made than physicians are willing to forgive themselves.

Keep in mind that failure to disclose mistakes can lead to allegations of fraud and negligent concealment (19–23). Such claims are not only uninsurable but also may lead to the awarding of punitive damages, which in many cases are also uninsurable.

Many physicians are unsure about how to disclose a medical error and when to do it. The short answer is as soon as possible. Timing is crucial, and once it is clear that a medical error leading to a complication has occurred, the physician should disclose all relevant information to the patient as soon as possible after verifying the facts. Delaying the discussion only makes it more difficult for a patient to accept and may cause the patient to believe that the physician is trying to hide information. Keep in mind that a defensive or accusatory response will only inflame the situation. A better approach is to focus on the current health needs and stick to the known facts. It is important to refuse to speculate on causes or outcomes and to resist the impulse to blame the patient or anyone else involved. Even if a physician thinks someone else made a mistake or caused the problem, he or she should wait for the results of the event analysis. The first take on an event can turn out to be incorrect. Physicians should be especially prudent about blaming themselves. Many physicians have rushed to confess their shortcomings only to find out later that the outcome was unrelated to the care given.

First and foremost, express empathy for the patient's pain and suffering. Second, do not hesitate to provide the patient with all known facts. Remember, patients have a need and a right to know about their medical conditions. They can and will request copies of their medical records. And alone, or with the help of an attorney, patients will be able to reconstruct the facts of the case sooner or later. Physicians have little to lose and much to gain by disclosing facts. Most importantly, a frank discussion without speculation or blame will begin the process of restoring a patient's faith and trust, which will enable the physician to give the best possible care going forward.

To summarize, when an adverse or less-than-optimum outcome occurs, it is recommended that the physician implement the following plan of action:

- Recognize the patient's frustration and possible fear
- Recognize your own feelings of disappointment and anxiety
- Don't panic—keep lines of communication open
- Express regret that the adverse result occurred but avoid finding fault or blaming others
- Explain what happened and the proposed plan of action in terms the patient can understand
- Keep the patient and family informed and involved in subsequent treatment plans and discussions; document the discussion in the medical record
In any situation, good physician-patient communication is the mainstay of a therapeutic, mutually respectful, and trusting relationship. The advice of treating each patient as you would want a close family member treated will give a physician all the guidance needed.

References


