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**TREATING PATIENTS WITH C.A.R.E.
ANNOTATED BIBLIOGRAPHY**

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Andaleeb, S. S. (1998). "Determinants of customer satisfaction with hospitals: a managerial model." International Journal of Health Care 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]

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

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

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

Subjects: n=130

Intervention: none

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

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

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

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

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.

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

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

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

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

Intervention: Baseline data on residents, staff, and their behavior were gathered for 4 weeks. During week 5, communication-memory book skill in-service workshops were conducted on the treatment units. Role-play, discussion of real-life examples, and discussion of written vignettes were part of the communication-skills training. Staff were trained in using the memory books to increase communication among residents and between residents and staff, to increase residents' independent functioning, and to distract residents to decrease disruptive behaviors. Memory books contain images and brief sentences that provide cognitive stimulation to patients and facilitate communication with staff and others. After the initial in-service training, resident were given a personalized, 12-page memory book with biographical, orientation, and daily schedule information. Hands-on training in communication and memory book use continued for 4 weeks. Supervisory staff and researchers observed each CNA once a day during their shift and provided feedback on their use of the communication skills taught during the in-service (staff motivational system). Supervising LPNs were also observed by the project manager and were given feedback on their supervision of the CNAs. Thirty-nine CNAs in the treatment group were taught to monitor and record their skill performance to both track their skill-usage and to motivate them. Trained CNAs who met 80% of the skills criteria received public recognition on the CNA honor role once a week and were entered into a lottery for a prize.

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

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

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

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

Bursch, B., 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. [Abstract from author]

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

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

Setting: A home care organization and a nursing home

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

Intervention: Nurses participated in a series of communication skills trainings. Training focused on developing nurses' awareness of the physical, social, and emotional needs of the elderly, verbal communication techniques (i.e. "structuring" and "exploring patients' ideas and opinions"), using active listening skills (paraphrasing, "mhm") to enhance patients' feelings of competence, asking open ended questions, and nonverbal behaviors (eye contact, leaning forward, smiling, head nodding, touch). They spent 2 days learning about communication theory, communication with the elderly, Video Interaction Analysis, and role-playing nurse-patient interactions with trained actors. Pairs of nurses then spent 6 Video Interaction Analysis sessions watching videotape of their own behavior during care giving and discussed their behaviors with the trainer. Learning took place in 3 ways: the participants' review of their own performance, feedback from the trainer, and peer comments. Video Interaction Analysis was meant to improve nurses' communication skills so that they would pay more attention to patients' physical and social needs, facilitate self-care in elderly patients, and support

patients in finding their own solutions to problems. During the 6-week periods between sessions, participants practiced their new skills and recorded a new caring interaction, which they analyzed on their own before the next session. At the end of the course, the participants held a group discussion about their experiences and evaluated the course structure, process, and their personal results.

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

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

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

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

Chang, B., 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 health care in the areas of their general and specific satisfaction.

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

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

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

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 health care prior to viewing the videotapes. After watching the tapes, a questionnaire was completed that focused on overall and specific satisfaction.

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

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

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. [Abstract from Author]

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

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

Setting: 84 dental offices in a medium metropolitan area in the Midwest

Subjects: 84 dental office staff

Intervention: none

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

Data Analysis: Communication behavior frequencies were calculated using descriptive statistics.

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

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

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]

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

Design: Cross-sectional, random, mail survey

Setting: 187 Emergency Departments from the Press, Ganey Associates database

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

Intervention: none

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

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

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

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

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

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

Design: Cross-sectional survey

Setting: 7 Southeastern nursing homes

Subjects: Nurses (n=200) and nurse assistants (n=358) [but only 61 nurses and 49 nurse assistants returned surveys]

Intervention: none

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

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

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

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

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

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

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

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

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

Abstract: Although US health care is described as "the world's largest service industry," the quality of service—that is, the characteristics that shape the experience of care beyond technical competence—is rarely discussed in the medical literature. This article illustrates service quality principles by analyzing a routine encounter in health care from a service quality point of view. This illustration and a review of related literature from both inside and outside health care has led to the following 2 premises: First, if high quality service had a greater presence in our practices and institutions, it would improve clinical outcomes and patient and physician satisfaction while reducing costs, and it would create competitive advantage for those who are expert in its application. Second, many other industries in the service sector have taken service quality to a high level, their techniques are readily transferable to health care, and physicians caring for patients can learn from them.

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. [Abstract from author]

Objective: To examine and describe patient communication styles

Design: Typology

Setting: Finnish hospital

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

Intervention: none

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

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

Findings: Seven patient communicator types were identified: quietly assenting, emotionally expressive, storyteller, stoic observer, inquisitive of detail, dominant, and critical self-observer. Communication behaviors for each type were described for the following features of communication: nonverbal, speech, manner of participation, topics, feedback, assertiveness, and contributing to the discussion. For quietly assenting patients (n=14), the norms for the discussion depended largely upon the practices of the hospital and the actions of the nurse. These patients are quiet and respond to nurses' questions, without bringing up other topics or expanding much on their answers. Emotionally expressive patients (7 women) discuss their feelings, talk for long periods of time, take initiative in making comments and expressing opinions, and seem to want to create a relationship with the nurse. Storytellers (5 men) used anecdotes and humor to discuss past experiences, and replied to nurses' questions in depth. Stoic observers (n=4) expressed themselves little and showed few emotions. Sometimes, the patients gave short responses despite long pauses between nurse's questions. At other times, patients who were giving longer responses or asking questions were interrupted or ignored by the nurse and then gave only short responses thereafter. Three patients were classified as inquisitive of detail. These patients were highly attentive and asked the nurse more questions than the nurse asked them. Dominant patients (n=3) were assertive, self-assured, and often critical or corrective of the nurses' comments. These patients also sidetracked the conversation into a peripheral topic and often controlled the conversation by using "I" statements and making their own judgments, predictions, and decisions. Critical self-observers (2 women) controlled the conversation by assessing their own actions critically, and by displaying their knowledge, skills, attitudes and behaviors regarding the health topic. They also discussed the pragmatic issues involved in carrying out health behavior instructions.

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

Lovgren, G., P. O. Sandman, et al. (1998). "The View of Caring among Patients and Personnel." Scandinavian Journal of Caring Sciences 12(1): 33-42.

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

Objective:

Design: cross-sectional, descriptive survey

Setting:

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

Intervention: none

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

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

Findings: The four factors which explained patient satisfaction were: 1) satisfactory relationship in care, 2) satisfaction with the way basic needs are met, 3) unsatisfactory relationship in care, and 4) satisfactory information concerning care after discharge.

The variables with the highest factor loading for each factor were: the personnel understand when I talk about my problems (1), the personnel respond to me in a loving way (1), I receive adequate help with hygiene (2), the personnel treat me in a nonchalant way (3), and I receive adequate information about access to help outside the health care organization (4).

Conclusions: Patients were least satisfied with their opportunities to express criticism with care or to receive information about access to care outside the health care organization. The oldest and youngest patients, and men, ranked their care experience higher, but patient satisfaction was high overall. Staff

underestimated patients' satisfaction, especially regarding whether they were treated lovingly, understood, and were able to express criticism.

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

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

Design: Pre-test/ Post-test

Setting: training workshop for health care professionals in Brussels, Belgium

Subjects: health care professionals (n=25); 72% nurses

Intervention: A psychosocial skills training workshop was conducted for 6-hours/ day during 18 days over a 20-week period (108 hours). 50% consisted of role-playing and 50% was education regarding psychological and psychiatric dimensions of cancer diagnosis & progression, patients' and relatives' coping mechanisms, loss and bereavement, psychological interventions, and other related issues. Female actors were trained to role-play a patient in scripted scenarios in which the emotional content was weakly, moderately, or highly emotional. Health care professionals role-played with the actors. Each health care professional role-played each of the 3 scenarios before and after the training workshop. Role-playing sessions lasted 20 minutes each.

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

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

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

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

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 nurturant quality of the baby talk tone of voice and parental style would compensate for the lack of respect associated with this type of patronizing talk to elders. The talk was either secondary baby talk or a neutral variant addressed to an elderly resident in the home by either a nurse or a volunteer. The caregivers who used baby talk were rated as significantly less respectful and competent than their peers

in the neutral condition, but no differences were observed for nurturance of the caregiver. The recipients of baby talk were perceived to be less satisfied with the interaction. Findings were true for both caregiver roles and both respondent age groups. [Abstract from author]

Objective: To examine young adults' and older adults' evaluation of nurses' and volunteers' respectfulness, competence, and nurturance and nursing home residents' competence and satisfaction with care, based on audiotaped conversations in which caregivers used either "baby talk" (high pitch, exaggerated intonation) or neutral speech when interacting with a cognitively alert nursing home resident.

Design: survey

Setting: university

Subjects: 80 university undergraduates, 71 older adults

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

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

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

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

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

Schweikhart SB and Strasser S. (1993) "Service recovery in health care 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 gynaecology, urology and continence outpatient clinics. The interviews were audio-taped and transcribed verbatim. The data was then coded and a thematic analysis carried out. The main theme to emerge was focused on patients' feelings about the procedure. This consisted of a combination of anxiety and embarrassment. Anxiety was because of fear of the unknown and embarrassment at the intimate nature of the procedure and lack of privacy. The interpersonal and communication skills of the health care professional were central in alleviating these negative feelings. The establishment of a friendly relationship based on equality and mutual respect and trust was important in preventing anxiety and embarrassment. A number of practical issues were identified that would contribute to improving the service for patients. It was found that nurses possessed all the attributes required to provide an effective service and recommendations were made that nurses specializing in continence care should take a more active role in urodynamic investigations. [ABSTRACT FROM AUTHOR]

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

Design: in-depth interviews

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

Subjects: n=21 (17 female, 4 male)

Intervention: none

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

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

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

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

Smoot, S. L. and J. L. Gonzales (1995). "Cost-effective communication skills training for state hospital employees." *Psychiatric Services* 46(8): 819-822.

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

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

Design: Quasi-experimental (intervention and control group), pre-test/ post-test

Setting: A short-stay adult inpatient psychiatric unit

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

Intervention: Staff were trained in communication skills using the Carkhuff Human Resources Development Model. The training focused on developing emotional and cognitive empathy to improve patient care and reduce caregivers' stress. The 32-hour program was held in sequential 8-hour sessions once a week for four weeks. Direct care staff as well as support staff received the training. The cognitive component of the training consisted of presenting a theoretical overview of the specific communication skill, a rationale for the promised effectiveness of the skill, and examples of the use of the skill (videotapes and instructor modeling). Role-playing allowed trainees to practice, receive

feedback, and observe each other. Role-playing familiar patient-care scenarios elicited emotional reactions among the trainees. Empathy was taught by reflecting message meanings back to the speaker. Skills included attending to patients' communications, accurately reflecting messages' content and communicators' feelings, responding to patients' requests, and making requests in a respectful and empathic manner. Nonverbal body language, such as squarely facing a patient and using eye contact, was also taught. Trainees were taught to paraphrase the content and feeling behind patients' communications and to ask patients to verify their interpretation. Trainees were taught to respond respectfully to patient requests by paraphrasing, getting feedback, and explaining the rationale for complying or not with the patient's request. Staff were also trained how to make respectful requests by providing verbal and nonverbal reinforcement for compliance and to respond to noncompliance by giving a verbal warning about the consequences of noncompliance.

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

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

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

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

Thompson DA, Yarnold PR, Williams DR, Adams SL. (1996). "Effects of actual waiting time, perceived waiting time, information delivery, and expressive quality on patient satisfaction in the emergency department." *Annals of Emergency Medicine* 28(6): 657-665.

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

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

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

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

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 analysed using descriptive and multivariate analyses. The findings of the study indicate that the needs of the relatives of stroke patients are best divided into three categories. These are the need for information, counseling (a combination of communication and support) and accessibility. In all cases, the most important need of the relatives of stroke patients is that their questions are answered honestly. The findings show a discrepancy between the importance of the needs and the degree to which these needs are met. Multivariate data analyses show that female relatives requested most information, whereas highly educated relatives needed less counseling. Satisfaction about the care provided is positively influenced by the period of hospitalization and negatively influenced by prior experiences of hospitalization. [ABSTRACT FROM AUTHOR]

Objective: To identify the needs of the relatives of hospitalized stroke patients and the factors that influence those needs.

Design: Cross-sectional questionnaire

Setting: 17 general hospitals and 2 university medical centers in the Netherlands

Subjects: 163 stroke patients' relatives (106 responded)

Intervention: none

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

Data Analysis: Reliability and validity were calculated. Communication and support were condensed into one category, counseling. Descriptive and multivariate analyses were conducted.

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

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

Vivian, B. G. and J. R. Wilcox (2000). "Compliance Communication in Home Health Care: 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 health care. The investigation focused on nurse-patient communication and the relational and content aspects of compliance communication. Six registered nurses and 25 adult patients from two cooperating home care agencies participated in this study. Observation during home visits and interviews with nurses and patients revealed a prosocial, collaborative model of compliance gaining. The findings show compliance communication to be embedded in nurse-patient conversations, with both nurse and patient engaging in control and affiliative behaviors. Implications for compliance research and the mutual-participation model of medical care are discussed. [Abstract from author]

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

Design: participant observation

Setting: Two home health care agencies in the midwestern United States

Subjects: 6 registered nurses, 25 adult patients

Intervention: none

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

orientation, and touch), as well as instances of verbal confirmation, and validating communications, were observed and recorded.

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

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

Conclusions: Educating patients by providing information, discussing the care regimens and their purpose, and by providing opportunities for patients to incrementally develop self-care skills, within the context of a respectful, supportive relationship, were the main ways nurses promoted patient compliance with treatment regimens.

Summary

¹C.A.R.E.

by

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Introduction

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

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

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

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

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

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

A Model For Communicating With Patients

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

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

In health care, more than in other work situations, it is important to have a specific process in mind for two reasons. First, many of the conversations that take place in health care

are very short, sometimes lasting less than a minute. Yet, within that minute, it is often important to use all four steps of the C.A.R.E. process.

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

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

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

CONNECT With The Patient

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPRECIATE the Patient’s Situation

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

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

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

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

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

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

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

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

A second way we can focus is by using a technique called reflective listening. When we do reflective listening, we act as a mirror for the patient. We say something to the patient that summarizes or compresses what they are trying to tell us. Sometimes it is easiest to preface this by saying something like, “*If I understand you . . .*” and then telling the person what your understanding is. For example, “*If I understand you, the office called and said that you were to be here at 9:30 for your test, you arrived on time and were told that you had no test scheduled today.*”

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

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

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

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

Acknowledge and express concern. There is a difference between observing and witnessing. An observer might see an event take place, be aware of the distress that people are

experiencing and never say a word. A witness, on the other hand, sees what is taking place, is aware of what is happening to others and then openly acknowledges what he or she is seeing and expresses concern. In human interaction, silence is sometimes not golden. We have all had the experience of trying to tell someone something that is important to us and all we get in return is a kind of stone silence. Most of us interpret that kind of non-response as: "He or she doesn't care."

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

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

RESPOND To The Patient

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

Listen carefully. When working with patients we often give our version of the non-denial denial. We don't answer the question. We may want to respond, but give an inadequate response because we didn't listen carefully to what the patient was saying. We may give an answer that has little to do with what the patient asked. So, the first task is to listen carefully and to ask us, "What is this patient asking?"

There are times that we may have a hunch that the patient is asking one question, but really wants an answer to another. When this is the case, it is best to answer both questions or at least to let the patient know we have heard both questions. *"Will my father be able to come home on Saturday?"* might really mean, *"Is my father going to be O.K.?"* We might answer: *"Your father is recuperating nicely and, if things keep going the way they are, he'll be able to go home*

Saturday or possibly Sunday.” Sometimes a patient will ask a question and we have a hunch that he or she is really making a statement rather than asking a question: “*Do patients complain about the food here?*” This might really mean, “*This food is terrible.*” We might answer, “*Yes some do. Others are actually a bit surprised and say they like it. What are your thoughts about the food so far?*”

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

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

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

“This procedure?”

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

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

“Yeah, that’s it.”

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EMPOWER the Patient

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

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

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

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

The shift in thinking is the movement from an assumption of patient helplessness to an assumption and acknowledgment of patient resourcefulness and competence. Members of the

health care team can actually train patients to be helpless, learned helplessness, rather than expecting them to be competent and autonomous. Specific techniques can help members of the team act on the assumption of patient competence and resourcefulness.

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

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

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

When we empower patients, we make ourselves available for questions: “*Your questions are helpful, please don’t hesitate to ask them.*” “*When you think of any questions, don’t hesitate to write them down and bring them with you.*” These approaches wind up saving time later on because the information we are providing is enabling the patient to be more competent.

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

Find out what the patient already knows. Don’t assume ignorance. The only way to find out what a patient knows or has been thinking about is to ask. For example, most patients come into a medical setting having already talked to others about the reason for their visit. In fact, most patients come in having already formed an opinion about what is wrong with them and the best

way to treat the problem. Asking is the safest strategy. *“What are your thoughts about what is wrong?”*

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

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

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

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

Summary

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

Attitude, attitude, attitude. Patients, not perpetrators. How we think about communicating with patients is critical. Our thinking, though, is translated into what we do — how we listen and what we say. The C.A.R.E. framework was developed as a tool for thinking about communicating with patients and suggesting ways to communicate with them. 1) *Connecting* with them as people; 2) *appreciating* the situation in which they find themselves and letting them

know we understand and are concerned; 3) *responding* to the problems they present and avoiding problems they might encounter; and 4) *empowering* them to work with us to address problems – these are all ways of increasing the effectiveness with which we communicate. Communication is often the most important means through which our patients know that we do care.