COMMUNICATING WITH PATIENTS AND RELATIVES

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PATIENT-CENTRED CARE
{ the heart of the matter }

> patient

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COMMUNICATION AND PATIENT-CENTRED CARE

“...care that is respectful of and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions”

COMMUNICATION AND PATIENT-CENTRED CARE

- Treating patients and families with dignity and respect

- Communication and sharing of unbiased information

- Patient and family participation in experiences that enhance control and independence and build on their strengths

- Collaboration in the delivery of care, policy and program development, and in professional education

Institute for Family Centered Care. Core principles of family-centered health care. Advances in Family Centered Care 1998; 4:2-4
Review the role of communication in clinical practice
Reflect on how medico-legal research has increased our understanding of the pivotal role of communication in ensuring patient satisfaction
Consider various communication strategies to ensure optimal relationships even in the event of an adverse outcome
THE ROLE OF COMMUNICATION

Art

Interpersonal skills

Science

Technical skills

Source: MPS
The role of communication

- Health Care Professional Privilege
- Ethical Relationship
- Better relationships
- Better time management
- Better relationships with staff and colleagues
- Decreased risk of litigation
BARRIERS TO QUALITY COMMUNICATION

- Practitioner issues:
  - Personal

- System issues:
  - Time
  - Patient flow
  - Resources
  - Cost
  - Working patterns
MEDICO-LEGAL RESEARCH AND THE ROLE OF COMMUNICATION
Patient motivation to take action

- Adverse outcomes in 3.7% of admissions
- 1 in 4 due to negligence
  
  Leape et al 1991

- 2 of 3 claims from patients with no adverse outcome or adverse outcome not due to negligence

- Only 3% of patients who suffered negligence filed a lawsuit
  
  Localio 1991

Source: MPS
25% due to negligence

But…60% of claims did not arrive from negligence and only 3% who suffered negligence formally complained!
PATIENT MOTIVATION TO TAKE ACTION CONT.

- 70% of litigation is related to poor communication after an adverse outcome where patients feel that they have:
  - been deserted
  - been devalued
  - lacked information, or
  - been misunderstood

  Beckman 1994

- 27% of surgical claims are related to poor explanation of the procedure to the patient

  Krause et al 2001

Source: MPS
FACTORS IN THE DECISION TO TAKE ACTION

Predisposing factors
- Rudeness, delays, inattentiveness, miscommunication, apathy, no communication

Precipitating factors
- Adverse outcomes, iatrogenic injuries, failure to provide adequate care, providing incorrect care, system errors, mistakes

Bunting et al 1998

Source: MPS
FURTHER ANALYSIS OF COMPLAINTS

- 10% of doctors are responsible for over 60% of complaints
  Hickson et al 2002

- No evidence of variable quality of care between doctors
  Entman 1994

- Predictive behaviour patterns for complaints
  patient complaints of rudeness, not returning phone calls, failure to show respect
  Hickson 1994

Source: MPS
What Conclusions can we Draw?

In the absence of predisposing factors, a precipitating factor is unlikely to lead to patient action against a doctor....

Predisposing factors are directly related to the quality of interaction we have with our patients....

A satisfied patient makes a satisfied doctor...
MAKING COMMUNICATION AN ACTIVE, EFFECTIVE AND EFFICIENT PROCESS

- Communication is both non-verbal and verbal
- Making a human connection early is important
- Listening is just as important as talking
- Conveying empathy assists patients to feel heard and understood

Source: MPS
Making communication an active, effective and efficient process

- Patients form rapid assessments of doctors’ interpersonal competence

- They are concerned with three key questions:
  - Are you listening?
  - Do you care?
  - Are you going to get this right?
  - diagnosis
  - treatment

Source: MPS
THE PATIENT HAS A STORY TO TELL

- Patients have rehearsed their 'story'
- Telling you their story is very important
- Doctors interrupt stories from patients very early
- Patients may not let you 'move on' till they've told their story
- Patients have a clear expectation that you will listen to their story
- Failure to listen may lead to perceptions the consultation was 'rushed' or you are not interested
- Non-verbal communication in this phase is critical

Source: MPS
COMMUNICATION AND PATIENT EXPECTATIONS

Identifying and addressing patient expectations is crucial.

Source: MPS
COMMUNICATION AND PATIENT EXPECTATIONS

- The personal qualities of the doctor
- The quality of the treatment received
- The size of the account
- How they will be treated as people
- How much time will be spent with them
- Doctor availability
- Competence
- How ancillary staff will treat them
- Amount of information they will receive

Source: MPS
Establishing Patient Expectations

- Indicates to a patient that what is important to them is important to you
- Seek patient’s expectations explicitly
- This can happen by asking specific questions:
  - What were you hoping to achieve today?
  - What else would you like to discuss today?
  - Are you sure there's nothing else?

Source: MPS
ASSESSING COMPETENCE

- Patients have difficulty assessing your clinical competence

- Quality of the interaction can become the 'de facto' standard of clinical competence

- If the quality of the interaction is low, patients may infer the quality of clinical care is low

Source: MPS
CONVEYING EMPATHY

Techniques

Short summarising statements:
• content
• emotions

Results

• Patient feels understood and appreciated
  Sung et al 2004

• Shorter consultations
  Levinson 2000

Source: MPS
SOME TECHNIQUES FOR IMPROVING NON-VERBAL SKILLS

- Mirroring body language
- Matching voice and vocabulary

Source: MPS
MIRRORING

 Technique:
 • adopt the postures, gestures and expressions of the patient
 • maintain eye contact

 Results:
 • enhanced patient feeling of connection and of being understood

Source: MPS
MATCHING VOICE AND VOCABULARY

- The patient's perception of understanding and concern can be enhanced by matching his or her:
  - rate of speech
  - volume of speech
  - vocabulary

- Matching of vocabulary by the doctor leads to significantly higher patient satisfaction

  Williams and Ogden 2004

Source: MPS
TONE OF VOICE IS IMPORTANT

- Surgeons with history of two or more claims were accurately identified by assessment of tone of voice from 10 second sound bites!

Ambady & LaPlante et al 2002

Source: MPS
COMMUNICATING WITH RELATIVES

- Valuable in the doctor-patient relationship

- Information sharing should be in the context of the duty of the confidentiality owed to the patient
  - Permission must be sought and consent obtained prior to any discussion
  - Be clear as to what the patient would like to be discussed
  - Gold standard is to have these discussions in front of the patient
  - Record the content of any discussion in the patient’s record
COMMUNICATING WITH RELATIVES

Request by relatives to withhold information:

- Happens frequently

Principles:

- Explain that patient needs to understand as much as possible – diagnosis and treatment
- Your obligation is to interact with all your patients honestly
- Be prepared to justify your actions and document all discussions
# Communication and Patient-Centered Care

Table 1

<table>
<thead>
<tr>
<th align="left">Behavioral Characteristics of Patient-Centered and Doctor-Centered Approaches to Communication</th>
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<tbody>
<tr>
<td align="left"><strong>Patient-Centered</strong></td>
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<tr>
<td align="left">Solicits and acknowledges patient concerns and uses them to build agenda</td>
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<tr>
<td align="left">Asks explicitly about the patient’s thoughts</td>
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<tr>
<td align="left">Encourages patients to express their feelings</td>
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<td align="left">Solicits patient involvement in decision-making</td>
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# Communication and Patient-Centered Care

<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Patient-Centered Model</th>
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<tbody>
<tr>
<td>Patient’s role is passive (Patient is quiet)</td>
<td>Patient’s role is active (Patient asks questions)</td>
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<tr>
<td>Patient is the recipient of treatment</td>
<td>Patient is a partner in the treatment plan (Patient asks about options)</td>
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<tr>
<td>Physician dominates the conversation (Does not offer options)</td>
<td>Physician collaborates with the patient (Offers options; discusses pros &amp; cons)</td>
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<tr>
<td>Care is disease-centered (Disease is the focus of daily activities)</td>
<td>Care is quality-of-life centered (The patient focuses on family &amp; other activities)</td>
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<td>Physician does most of the talking</td>
<td>Physician listens more &amp; talks less</td>
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<tr>
<td>Patient may or may not adhere to treatment plan</td>
<td>Patient is more likely to adhere to treatment plan (Treatment accommodates patient’s cultures &amp; values)</td>
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COMMUNICATION AND RISK MANAGEMENT

Risk Management

Risk Control
- Incidence
- Causation
- Prevention

Loss Control
- Containing loss
- Sharing loss

Source: MPS
Patients do not care how much you know until they know how much you care

Scherger 2001
THANK YOU