

Dealing With Breakdowns in Communication

One day Nancy Radcliff, R.N., was shadowing an orthopedist in his office. Ms. Radcliff, director of customer service for the Bronson Customer Service Institute at Bronson Hospital in Kalamazoo, Mich., is frequently hired by corporations, hospitals and physicians to diagnose and cure their communication problems, which are often in critical condition.

Communication problems between physicians and their staff, patients and colleagues can damage hard-earned reputations and lead to lawsuits. Lack of communication is often the culprit behind high staff turnover, patient dissatisfaction and plunging profits. Physicians can resolve many issues by simply replacing bad habits with effective communication strategies that create harmony in the workplace.

When the physician and Ms. Radcliff walked into the exam room, a couple was holding hands. The wife was the patient, but the physician addressed only the husband. The doctor viewed her X-ray on a light board, discussed her condition with his back turned toward them, then walked out of the room adding, “We need another X-ray.”

“I was absolutely astounded—flabbergasted,” recalls Ms. Radcliff. “This physician didn’t have any concept of what his communication skills were. He had a sense

he was not communicating well only because [he was involved in] lawsuits.”

Communication problems between physicians and their staff, patients and colleagues are nothing new. Besides lawsuits, poor communication can seriously damage hard-earned reputations and is often the culprit behind high staff turnover, patient dissatisfaction and plunging profits.

Physicians can resolve many issues by simply replacing bad

habits with effective communication strategies that create harmony in the workplace. Learning new skills along with exercising a little discipline can make office problems and related stress melt away while preventing new ones from materializing.

The first step is to evaluate your communication skills. Do you speak in sophisticated medical jargon to patients, or do you translate medical information into layman's terms? Do you greet people by name or shake their hand? More importantly, are you a good listener? Do you allow patients enough time to express their concerns and ask questions?

Some physicians hire consultants to perform an annual assessment of their skills, while others ask office staff to periodically observe them with patients, then evaluate the interaction. But employees will share honest feedback only if they believe they're in a trusting and safe environment and that their constructive feedback will be seriously considered by the physician.

Just as your car needs a tune-up or routine maintenance, so do your communication skills. Some physicians hire consultants to perform an annual assessment of their skills, while others ask their office staff to periodically observe them with patients, then evaluate the interaction. But employees will share honest feedback only if they believe they're in a trusting and safe environment and that their constructive feedback will be seriously considered by the physician, says Ms. Radcliff.

Another common method is called a 360 review or evaluation. Dr. Edward T. Creagan, a cancer specialist at the Mayo Clinic in Rochester, Minn., prescribes this approach for every physician. This tactic allows you to solicit anonymous feedback from multiple sources, which can show you how you are perceived by others.

To conduct a 360 review, identify between 20 and 25 colleagues. Ideally, one-third should be those to whom you report, another third should be those who report to you, and the remaining third should be your peers. This group could include people with whom you occasionally interact, including colleagues you may have only met on-line.

Ask them to fill out a questionnaire about your performance. Dr. Creagan says there are many consulting groups that can draft a standard survey that will touch on different aspects of your

communication abilities. Your colleagues then send their survey to the consulting group, which collates the responses and anonymously shares the results with you.

“It’s incredibly powerful because it tells us where our blind spots are,” says Dr. Creagan, author of *How Not to Be My Patient: A Physician’s Secrets for Staying Healthy and Surviving Any Diagnosis* (HCI, 2003). “In general, most people will not be in your face and say you’re doing something really stupid. I’ve found this incredibly valuable because many of us may be doing the same dumb thing for 30 years and we don’t know it.”

During his own 360 review about two years ago, Dr. Creagan was criticized for not being a mentor or not being more visible to younger colleagues. He says he was devastated and completely clueless that he was perceived as being a lone ranger. The feedback jolted him enough to change his behavior. Since then, he has carved out more time and extended himself to younger physicians.

Once you’ve gathered this feedback, analyze it as if you were diagnosing a chronic illness. Examine the symptoms, what triggers your behavior and potential treatment options. Just remember that the hardest step is always the first—admitting that your communication skills need improvement.

Techniques That Work

How long do you let patients speak before interrupting them? The results of a survey published by the *Journal of the American Medical Association* revealed that after physicians solicited patient concerns in 199 interviews, only 74 patients were able to complete their opening statements. The remaining patients were interrupted by physicians after 23.1 seconds. Those who were allowed to complete their statements spoke on average for only six more seconds than those who were interrupted. The authors’ conclusion: “Consequences of incomplete initial descriptions include late-arising concerns and missed opportunities to gather potentially important patient data. Soliciting the patient’s agenda takes little time and can improve interview efficiency and yield increased data.”

Although these results were published in 1999, not much has changed in the area of physician-patient communication, says Robert James Cimasi, president of Health Capital Consultants, a

healthcare consulting firm in St. Louis. Because of financial pressures, he says, medical practices are often busy getting patients in and out of exam rooms and fighting with insurance companies to capture revenues. This leaves little time and energy for physicians and their staff to focus on anything else.

But the results can be very destructive. If patients perceive that their physician is abrupt and doesn't take the time to hear their concerns or complaints, chances are that they may not trust their doctor's medical advice, believing it is inappropriate for their condition. That can quickly lead to another series of problems involving patient compliance, such as patients taking incorrect doses or not taking prescribed medication at all.

"The physician must make it clearly understood that the patient comes first," says Mr. Cimasi. "This has to become the shared value of every person in the practice."

Staff must be trained to work synergistically with physicians so that the entire office demonstrates mutual respect for each other and patients. If achieved, patients feel valued, are more apt to follow directions and truly feel as if the physician and staff are on their team.

The process, however, involves periodic tracking and monitoring of common office functions. For example, keep track of how many calls you get each day. Are certain times of day or week busier? If so, you can bring in additional people during peak hours, allowing you or your staff to spend several extra minutes answering Mrs. Jones' questions or to call Mr. Smith to make sure he's taking the correct dose of his medication.

Sharp Mission Park Medical Group in Oceanside, Calif., routinely surveys its patients and receives between 4,000 and 5,000 responses every year. What's the biggest patient complaint? More than half feel rushed through visits, says Christine Mingst, director of patient care at Mission.

The organization trains its physicians on how to change patient perception and improve patient satisfaction. For example, physicians are taught to sit down in the exam room, establish eye contact with patients, never turn their back on them, touch them on the shoulder and always ask before the end of each visit, "Is there anything else I can do for you?"

A staff member also calls patients on a random basis. Maybe

the patient's visit included an office procedure or a newborn received an injection. Patients visiting Sharp's urgent-care center also receive calls. Ms. Mingst says the phone calls usually start off with, "Dr. Smith was concerned about you and wanted me to follow up. How was your visit with us? Is there anything else we could have done to improve our service for you?"

She says the reaction has been very positive. Common responses include, "I can't believe you're taking the time to call me," "You must really care about me," or "I really appreciate it."

Other doctors write social progress notes in the margins of each patient's medical record and review those notes before walking into an exam room.

Dr. Susan Bane, an obstetrician/gynecologist at Physicians East/Greenville OB/GYN in Greenville, N.C., says her notes can include such personal information as the fact that the patient attended school with her

mother, was recently married or has a young daughter who was recently diagnosed with cancer.

"When I walk into the room, I can start off the conversation with something besides their health," she says. "The person feels as if you care about them. That often sets them at ease. And it's a lot more fun than just talking business."

Other tips she recommends: start off with a handshake, pat on the back or hug—depending upon how well you know them. If your practice is fully computerized with computers in each exam room, don't type your notes into the computer while engaged in a conversation with the patient. While it may save time, patients may perceive that as very cold and impersonal, she says. Be sure to make eye contact.

Dr. Bane also writes letters to patients to connect with them. For example, every time she delivers a baby, the parents receive a letter of congratulations. Other times, her letters offer emotional comfort or guide patients through difficult situations. Once, she

Dr. Susan Bane, an obstetrician/gynecologist in Greenville, N.C., says that when she walks into the exam room, she starts off the conversation with something other than the patient's health. "The person feels as if you care about them," she explains. "That often sets them at ease. And it's a lot more fun than just talking business."

diagnosed a young college student with herpes, and the patient thought her life was over. Dr. Bane sent her a note saying, “We all make mistakes. You’re going to be fine.”

Physicians can offer their personal touch in many different ways. For example, after performing surgery, Dr. Bane waits until that night or the following day to talk with patients. Conversely, she says, many physicians speak with patients while they still may be groggy from the anesthesia; those patients likely will not remember the conversation the following day.

A handful of physicians are sharpening their communication skills at the National Institute of Whole Health in Wellesley, Mass. The organization provides continuing education for medical professionals in “whole-person healthcare,” explains its director, Georgianna Donadio, Ph.D.

She says that one of the biggest patient complaints is that physicians and other healthcare providers typically don’t “communicate authentically” or show respect. For example, she says, when you sit in an exam room with patients, are you really lis-

Put the Message to Music

Dr. Mabelle Seibel, who runs the menopause program at the University of Massachusetts in Worcester, Mass., realized that many patients don’t remember, understand or listen to important health messages from their doctor. So about two years ago, he decided to do something about it.

He set his messages to music. He formed a new company called Health Rock and began writing and singing songs on a variety of topics ranging from incontinence and depression to vaginitis and growing old gracefully, then recorded them on CDs.

His voice is “passable,” and most of his songs are under one-and-one-half minutes in length. “They’re about things you wouldn’t think you could sing about, but in fact you can,” he says.

While he doesn’t expect to appear on MTV anytime soon, he’s also working on animating some of his songs for his Website as public service announcements and hopes the animations will be broadcast on TV in the near future.

Dr. Seibel’s CDs are available on his Website (www.healthrock.com) for \$16 each.

tening to them or are you thinking about your stockbroker or about going to Bermuda over the weekend or what you'll eat for lunch? Are you "present" to that person and actually giving him or her your time and paying attention to the task at hand?

Dr. Donadio says that 70 percent of information is communicated through nonverbal means. Patients can sense when you're not present through a variety of verbal and nonverbal cues, such as lack of eye contact, leg shaking, tone of voice, facial expression and hand gestures. Then there is the distraction factor—how many times do you answer phone calls or walk out of the exam room during a patient encounter?

"Clear your mind, clear out all the nonsense that's not related to that particular person," Dr. Donadio says. "Give them what they paid for, and you'll get back 10 times in good will, recommendations and referrals. The biggest and most successful practices in the U.S. are all word-of-mouth referrals. We know that's a fact, yet somehow we don't think we have to be mindful of how people are experiencing our care."

The organization conducted a four-year trial study between 1998 and 2002. Fifty patients, who were labeled noncompliant and suffered from multiple pathologies ranging from cardiac disease and obesity to alcoholism, were enrolled in the Cardiac Rehabilitation Department at Union Hospital in Lynn, Mass. Patients were evaluated at the beginning and end of the study using SF36, a validated survey instrument that is used to measure quality of life. Six educators and six interns from the New England School of Whole Health Education participated in educating the patients at the hospital during six one-on-one sessions.

The study found that these patients performed significantly better than the control group after just six months. There was an 11-percent improvement in patients sharing their feelings, a 6-percent improvement relating to stress, 22-percent improvement in their perception of their tendency to get sick compared with others, a 21-percent improvement in their expectations of future health decline and a 4-percent improvement in their perception of their current health status.

One participant was an alcoholic in his early 50s who suffered from diabetes, heart disease and cancer. Several months into the study, Dr. Donadio says, he ran into his doctor in the hospital's

hallway; he had not seen this physician since he was enrolled in the study.

“His doctor didn’t recognize him,” she says, explaining that this man was now standing straight instead of being hunched over, had color in his face and had lost weight. When asked what had happened to him, the man said, ‘Finally I got somebody to tell my story to. She listens.’ The doctor was transformed.”

The golden rule that the National Institute of Whole Health teaches is that nobody likes to be told what to do. Patients must be engaged and invited into the process of managing their health-care. In order for that to occur, physicians must create a level playing field that involves shared decision-making and trust patients’ intelligence and intuition when it comes to their own bodies. She says that many physicians do not ask their patients

Patients Uneasy About Confronting Care Providers: Study

A recent study suggests that patients often play an unwitting role in bringing about medical mistakes by not confronting their healthcare practitioners when they have concerns about their care.

The study, conducted by VitalSmarts, an international company that provides leadership training and consulting services, identified patients who had recently encountered problems from feeling mistreated by healthcare practitioners to feeling worried that their care provider was making a significant mistake. It found that patients usually say nothing about their concerns, and their silence puts them at risk for significant personal harm.

“Patients often find themselves in a quandary, worrying that their healthcare professional is acting on poor information,” says Joseph Grenny, author of the study and president of VitalSmarts. “The patients feel that they have to choose between being respectful and sharing their concerns. Given these two choices, they don’t speak up.”

The survey found the following:

- Fewer than half of patients spoke up when the caregiver was unclear about the diagnosis, treatment options or next steps.
- One in five of these people had suffered “substantial” health problems as a result of not speaking up.
- When patients believed that the care provider was making a medication error, they were more inclined to speak up, yet more than a third did not.

what they believe may be wrong with them.

Over a nearly 30-year span—from 1977 to 2005—the organization surveyed roughly 100,000 patients in the New England area and asked them that same question: What do you think may be wrong with you? The results found that 93 percent of the time, patients had accurately diagnosed their condition.

By asking that question to patients, Dr. Donadio says, physicians can begin to relate to patients as one human being to another. “Their eyes will brighten up, and they’ll think you’re pretty terrific because you’ve engaged them in shared decision-making,” she says. “How powerful is that?”

Is the patient a single mother working two jobs to support a large family? If so, advising her to start an exercise routine, avoid starchy foods and eat fruits and veggies would be a waste of time. The patient would feel as if the doctor doesn’t understand anything about her and “blow off” anything else that’s suggested.

Another reason to ask the question is that many times, patients don’t reveal the real reason behind their visit. They’ll talk about their hypertension, then as the doctor is walking out the door, add, “By the way, I’m having chest pains.”

Dr. Edie Leggold, medical director at the Center for Women’s Well Being in Milwaukee, Wis., begins each visit with new patients by asking them questions about themselves, such as where do they work or the ages of their children, develops or reviews a list of their medications, then asks them why they came to see her.

She says that gives them permission to talk about what’s really bothering them. “I know how doctors work,” says Dr. Leggold. “They’ll take their history, get their medication, do an exam, but never ask the patient. They assume patients will say they need more blood pressure medicine. But they’re really here because they’re having abdominal pain and it’s really scaring them.”

Then there’s the list—the dreaded list of questions that patients bring with them to each doctor appointment. Dr. Leggold believes that if there’s anything that makes a doctor’s stomach turn, it’s the list, mostly because patients are extremely unrealistic. They will want answers to a dozen complex questions during a 15-minute exam.

Usually, she says, the list contains questions about a wide variety of symptoms and conditions ranging from chest pains to toenail fungus. Instead of tackling all the questions, however, she reviews the list, picks one question and asks the patient to pick another, then encourages him or her to schedule additional visits.

During their visit, she also pays attention to their personal situations. Is the patient a single mother working two jobs to support a large family? If so, advising her to start an exercise routine, avoid starchy foods and eat fruits and veggies would be a waste of time. The patient would feel as if the doctor doesn't understand anything about her and "blow off" anything else that's suggested.

Dr. Edie Leggold of Milwaukee explains her rationale for her frequent calls to patients with a joke repeatedly told by physicians: Patients call, call, call, they're not better, they're not better, they're not better. Then they don't call anymore. They're either better or they're dead. "I prefer to know that they're better," she says.

The same holds true with medicine. How many doctors prescribe expensive drugs for elderly

patients who are on a fixed income? Dr. Leggold, who previously worked at an inner-city practice for 14 years, says that more than half of the seniors in the country don't take their medicine because they can't afford it. "When I work with a poor population, I'm very open about their ability to pay for medicine," she says. "I ask them in a way that's not intimidating: 'Please tell me if you're not able to pay for your medicines.'"

Her communication goes one step further. Dr. Leggold personally calls patients if they're seriously ill, received an abnormal reading on a recent lab test or were referred to a specialist. She keeps an ongoing list of patients with active issues and says it is easy to keep those calls to one minute or less by simply asking, "I was concerned and wanted to know how you're doing." Patients appreciate it, she says, and it also makes her feel good knowing the status of their health.

To demonstrate her point, she tells a joke repeatedly told by physicians: Patients call, call, call, they're not better, they're not better, they're not better. Then they don't call anymore. They're either better or they're dead. "I prefer to know that they're better," she says.

Patients Value Physicians' Interpersonal Skills: Survey

Patients say that a physician's interpersonal skills are more important than his or her medical judgment, experience and training, according to a 2004 survey by The Wall Street Journal Online/Harris Interactive Health Care Poll. The survey polled 2,267 adult patients and asked them to rate the importance of qualities of their treating physicians and whether their doctors possess those qualities.

	Extremely Important	Describes Your Doctor Well	Gap
Treats you with dignity and respect	85%	73%	-12%
Listens carefully to your healthcare concerns and questions	84	68	-16
Is easy to talk to	84	69	-15
Takes your concerns seriously	83	69	-14
Is willing to spend enough time with you	81	62	-19
Truly cares about you and your health	81	63	-18
Has good medical judgment	80	65	-15
Asks you good questions to really understand your medical conditions and your needs	79	61	-18
Is up-to-date with the latest medical research and medical treatment	78	54	-24
Can see you on short notice if necessary	71	53	-18
Responds promptly when you call or e-mail with questions or concerns	60	38	-22
Has a lot of experience treating patients with your medical condition(s)	58	45	-13
Could get you admitted to a leading hospital when you need it	55	46	-9
Has been trained in one of the best medical schools	27	25	-2

Source: Wall Street Journal Online/Harris Interactive Health Care Poll.

At Dr. Neil Baum's urology practice in New Orleans, all employees wear name badges and introduce themselves by name. While in the exam room, patients also watch a three-minute video that introduces Dr. Baum, his staff and the practice's services.

Before the appointment, a "Welcome to the Practice" package is sent to the patient. This mailing contains essential forms that patients must complete and also reminds them to drink plenty of water before coming, since they will need to give a urine sample.

Dr. Baum begins every visit with patients by first referring to their social progress notes, then engaging them in a several-minute discussion on a non-medical topic to establish rapport. "They care that you know about them as an individual," says Dr. Baum, author of *Marketing Your Clinical Practice Ethically, Effectively and Economically* (Jones & Bartlett Publishers, 2004). "If I walk in and say, 'Tell me about your problem with urinary incontinence,' that means I'm only treating them as a bladder and a kidney."

Medication Compliance

One of the most important conversations that exist between physicians and patients revolves around medication. Physicians must answer a series of questions, such as why the drugs are being prescribed, how often patients should take the medication and what the potential side effects are.

But unfortunately the communication process doesn't always go smoothly. According to findings from a 2005 study by VitalSmarts and the American Association of Critical-Care Nurses (AACN), poor communication and collaboration among health-care professionals "relate significantly to continued medical errors and staff turnover."

In the study, fewer than 10 percent of the 1,700 people who responded said that they routinely address the following kinds of behavior by colleagues: trouble following directions, poor clinical judgment and taking dangerous shortcuts.

"Too often, improving workplace communication is seen as a soft issue—the truth is we must build environments that support and demand greater candor among staff if we are to make a demonstrable impact on patient safety," said Kathy McCauley,

R.N., president of AACN.

Dr. Shawn Christopher Shea, psychiatrist, director and founder of the Training Institute for Suicide Assessment and Clinical Interviewing in Stoddard, N.H., recognizes the problem all too well. He trains physicians on patient compliance issues, specifically how to talk to patients about their medications.

When physicians initially discuss medications with patients, he says, patients are determining whether their doctor is trustworthy or simply “trying to push meds,” he says, adding that it doesn’t matter what condition the drugs are prescribed to treat.

“I would argue that in most patient-physician relationships, the patients’ final decision as to whether they can trust the physician, like the physician or can work with the physician really is born from how those physicians and patients actually resolve their medication issues,” he says.

Dr. Shea has developed a collection of different interviewing techniques about how physicians can talk to patients taking medication. Doctors from all disciplines around the country have e-mailed their best interviewing tips to him. Each month he features a new tip on his Website (www.suicideassessment.com); the site now offers more than 60 tips, most of which are applicable to primary-care physicians.

One tip he refers to is called Lost Dreams, which addresses how physicians can motivate patients to take their medicine on a routine basis. Regardless of their illness or the reason they need the medicine, he says that physicians need to ask patients, “What is your illness or condition stopping you from doing?” A teenager, for example, might complain about not being able to play soccer anymore. A senior citizen might respond, “I can’t take my grandchildren to Disneyland.”

How the physician replies is very important. Consider this response: “I’ve worked with many people who’ve had a condition similar to yours. While I can’t promise that it will definitely

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work, I've had some really good luck helping these patients by using certain types of medication. What I'd like to do is see if you and I can agree that a common goal for us is to try to get you back out on that soccer field (or get you to Disneyland)."

By answering this question, Dr. Shea says, patients of any age can tell physicians what matters most to them and what the doctor can do to help them achieve their lost dream. It also minimizes any oppositional aspects of the relationship.

However, if a physician needs to increase the dosage of any medication, the patient's opinion of the current dose is going to be a dramatic player in how well the information is received. In other words, if you're raising the dosage on medications for patients who believe they're taking too much, he says, physicians might as well pull a lever on a trap door. The patient's compliance and interest in the drug are going to plummet.

Instead, physicians need to ask, "In your opinion, do you feel you're on too little, too much or just the right amount of this med-

Delivering Bad News

While conveying bad news to patients is challenging for any physician, not many have developed the skill or expertise to do so. Considering that most patients want to be informed about their illness, physicians can follow this six-step approach developed by The Education in Palliative and End-of-life Care project (EPEC) at the Feinberg School of Medicine, Northwestern University in Chicago. EPEC educates healthcare professionals on essential clinical competencies in palliative care (<http://epec.net/epec/webpages/ecommerce/itemdetail.cfm?productid=74>).

1. Getting started. Confirm the medical facts and ensure that all needed information is available. Create an environment conducive to effective communication and allot adequate time for discussion. Determine who else the patient would like to have present for the discussion.

2. What does the patient know? Establish what the patient and family know about the patient's health. Ask questions like, "What do you know about your illness?" or "What did the other doctors tell you about your condition or any procedures that you have had?"

3. How much does the patient want to know? Determine what and how much each patient or parent—if the patient is a child—wants to

ication?” Any response other than “just the right amount”—even a hesitation—will give physicians a chance to address their concerns before raising the dose and thus strengthen compliance.

Another communication tip: the first and last bits of information you mention to patients that are in a series of things are by far the ones they’re most likely to retain. So ask yourself: what are the two most important things you want your patients to know? Then when you speak with them, position the information first and last, he says.

Bond with Colleagues

In 2004, Dr. Walter Gaman faced a communication crisis. As a family practitioner and senior managing partner at Healthcare Associates of Irving in Irving, Texas, he believed that his physician partners were content with the way the practice was operating.

The practice routinely held meetings for physicians to address operational and clinical issues and allowed 10 minutes at the end

know by asking questions, such as: “Would you like me to tell you the full details of your condition? If not, is there somebody else you would like me to talk with?” If family members ask you not to tell the patient the diagnosis or other important information, ask them why.

4. Sharing the information. Deliver the information in a sensitive but straightforward manner, then stop. Avoid a steady monologue. Use simple language. Pause frequently. Check for understanding. Use silence and body language as tools to facilitate the discussion.

5. Responding to feelings. People respond to news in a variety of ways ranging from tears to denial or shame. Be prepared to support patients and their family through a broad range of reactions. Acknowledge their emotions and ask them to describe their feelings. Several appropriate responses include: “I wish the news were different,” “I’ll help you tell your son,” or “What worries you most?”

6. Planning and follow-up. Establish a plan for the next steps. This may include performing further tests, helping parents tell their child about the illness and what treatment will be like for them and arranging for appropriate referrals and sources for emotional and practical support. Reassure the patient that he or she is not being abandoned and that you will be actively engaged in an ongoing plan to help.

of each meeting for physician input. Dr. Gaman noticed that during several of these meetings, a handful of his partners weren't offering any comment.

"I was lulled into a false sense of security that everyone was happy with everything," he says.

Then at one meeting, a physician's temper exploded. She accused some physicians of strong-arming her and others into making decisions they didn't agree with and never giving them an opportunity to speak.

The accused physicians sat there stunned, recalls Dr. Gaman, who believes the blowup resulted from misperceptions about people's different working styles.

Since then, he has purchased videos and audiotapes on how to interact with a diverse group of people, which prompted him to change some of his poor communication habits.

In the past, for instance, when physicians would enter his office, he was usually entering data into a patient's electronic medical record. He would continue typing his notes and listen to them with half an ear. Now, he says, he stops typing, listens to their concerns and initiates more eye contact.

"Little things like that don't seem like anything serious but are huge because people want to be heard, they want to know they're validated, that their concerns are going to be taken seriously," he says.

He also hired a chief executive officer to run the practice and another employee to manage public relations. Physicians now turn to the CEO with specific issues or concerns. Then the CEO discusses critical problems or those he can't resolve with Dr. Gaman during one meeting.

Likewise, the PR employee communicates with physicians outside the practice, sending them promotional or introductory letters and handling all of their requests. Since the two new staff members came on board, the practice is much busier and more profitable, Dr. Gaman says. What's more, employees and partners don't just appear happy, they are happy because there are more avenues to vent or share concerns.

Instead of hiring a person to handle PR, Dr. Jim Chlovechok used a marketing tool to open the lines of communication between himself and other local physicians. Dr. Chlovechok,

founder, president and medical director of the Ohio Sports Medicine Institute in Cambridge, Ohio, invited doctors—particularly emergency-room physicians—to an open house at his facility. The marketing strategy offered several benefits: it was an efficient way to introduce himself and his facility to local physicians, it helped him establish a connection with them, and it enabled him to get referrals.

Shortly after the open house, he received a number of thank-you letters. “Emergency-room physicians don’t very often get feedback,” he says. “They really appreciated it. It helps them manage patients in the future, shows them that you value their service and reinforces their behavior of sending you good patients.”

Whenever ER doctors phone him, he immediately takes their calls. Having served as an ER physician in the past, he says that physicians don’t realize that the ER doctors often see their patients—those who can’t get an immediate appointment, suddenly fall ill or maybe were seriously injured in an accident. By taking the ER physicians’ calls, he says, doctors communicate respect and an understanding that their time is important.

As part of a large medical group—Covenant Medical Group—Dr. Leppgold also interacts with a variety of doctors outside her clinic but within the organization. In the past, whenever she had questions, she would e-mail the other doctors. But two physicians never read their e-mail. So now she attends their office meetings, which she says has improved communication between them.

But she always takes a doctor’s call and wishes other physicians would do the same. She takes offense when she’s forced to play phone tag by leaving important messages. To avoid this in her own practice, she developed a list of healthcare professionals for her staff. When any of them call, her staff has been instructed to interrupt her.

Physicians must also pay attention to timing and location of

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their phone calls, says Ms. Radcliff. For example, have you ever left a patient in an exam room to answer a call using the hallway phone? Often, patients can overhear your conversation and may take offense, especially if it's a personal call. "It isn't that you shouldn't call people back, the location is poor," she says. "Go into your office. You may think it's impractical, but it's

Be Word Wise When Speaking With Patients

Choosing the right words when speaking with patients can greatly improve communications, according to Stephanie Barnard, a communication consultant and co-author of *Writing, Speaking, and Communication Skills for Health Professionals* (Yale University Press, 2001). She offers the following tips for physicians:

■ **Use positive words.** Positive words have been shown to be much more influential than negative ones. Rather than "Your blood sugar is way too high," try, "I'd like to see your blood sugar numbers come down to a lower level."

■ **Speak in specific terms.** Being as specific as possible helps decrease miscommunication. Rather than "You need to lose weight," instead try, "I'd like to see you lose about 20 pounds to reduce your risk for heart disease."

■ **Maintain good eye contact.** By maintaining good eye contact during a conversation, you will reflect confidence and show that you are a good listener.

■ **Ask questions to build rapport.** For example, "Do you have any concerns about knowing exactly when and how to take this medication?"

■ **Establish a need.** For example, "I am concerned because you have high blood pressure, and I want to encourage you to take steps toward preventing a heart attack."

■ **Focus the conversation on the benefits.** For example, "Even if you've smoked for most of your life, giving up cigarettes can prevent further damage to your heart. As soon as you quit, you also will begin to reduce your risk for developing lung cancer, other respiratory disorders and stroke."

■ **Close the conversation with a call to action.** "Let's set a reasonable goal for you to improve your heart health. Do you think you can find 30 minutes to go for a walk at least three times within the next week? Call my office and leave me a message regarding how you are doing with this goal."

absolutely necessary.”

Before physicians end a phone conversation with another colleague, they need to ask one important question: “Is there any other information you need?” or “Is there anything else I can do for you?”

Physicians frequently don’t ask either of these questions. That’s unfortunate, says Ms. Radcliff, because it’s one more way to build trust, establish a connection and demonstrate respect to another colleague.

Treat Staff as Internal Customers

One time, a patient in a hospital emergency room requested a pillow from a physician. The doctor walked out of the exam room, spotted a nurse in the hallway, snapped his fingers and told her to get a pillow for the patient.

Ms. Radcliff, who was working with the doctor at the time to help him improve his communication and customer-service skills, was shocked. She pulled the doctor aside and recalls their conversation as the following:

“What did you just do?” asked Ms. Radcliff.

“I met the needs of the patient—the patient asked for a pillow,” said the physician, who appeared very proud that he had implemented one of the patient satisfaction standards established by the Bronson Customer Service Institute.

“You highly offended me and the nurse,” replied Ms. Radcliff. “You need to apologize to her.”

“You’re kidding,” the doctor replied, who was clueless about why his actions were inappropriate.

Still, he apologized to the nurse for “barking at her.” The nurse smiled at Ms. Radcliff, recognizing that she had her work cut out for her.

As illustrated in this example, physicians sometimes treat their staff with disrespect without realizing it. Consider employees as internal customers. Would you snap your fingers at a patient or another healthcare provider? While the answer is obvious, this may not be: the way you treat your staff is also the way your staff may treat you, patients and each other.

“If physicians apply the same type of skill set they’ve learned in the clinical part of their life to the management of communi-

cation, they would be superstars every time,” says Mr. Cimasi. “But some can’t make that leap of applying the same skills and techniques to a different area.”

Dr. Chlovechok recalls the time when his sports-medicine clinic experienced growing pains. When the number of employees grew to 10, he says, there was office confusion. While every-

A basic strategy to avoid communication problems is one that many physicians are very familiar with, take for granted and don't use: staff meetings. Many in-house communication problems could be resolved with structured, routine meetings. A meeting also offers physicians a formal setting in which to compliment staff on their efforts or emotionally pat them on the back.

body was busy performing their own job tasks, somewhere along the way, they lost appreciation for related tasks being performed by their co-workers.

Trouble started when people began making decisions within their own department without considering how those decisions would impact other employees and other departments.

Recognizing his mistakes, Dr. Chlovechok began educating all staff as to the responsibilities of other people and their departments, and set up policies. One

such policy stated that all office issues, such as those related to personnel or service, would be handled by the office manager. Then he and the office manager met with each department head to explain the new policies. Another meeting was later held to explain the policies to remaining staff.

Although the process was cumbersome, Dr. Chlovechok says that by working in a top-down fashion, new policies were not introduced to staff before their manager understood or became aware of them. His office manager also “makes rounds” with employees on a routine basis to observe the workflow, identify or resolve potential problems and observe subliminal communication. If nothing else, he says, it helps build camaraderie and trust between staff and the office manager.

Another basic strategy to avoid communication problems is one that many physicians are very familiar with, take for granted and don't use: staff meetings. Dr. Gaman, for instance, readily admits that staff communication at his practice could be in bet-

ter shape. Currently staff meetings at his practice are conducted on an ad hoc basis. But, he says, many in-house communication problems could be resolved with structured, routine meetings. A meeting also offers physicians a formal setting in which to compliment staff on their efforts and hard work or emotionally pat them on the back.

Dr. Leggold increased her staff meetings from every month to every two weeks; the meetings last between 45 minutes to an hour. They include an open session during which all employees are encouraged to bring up issues or problems. Although they don't expect to resolve their problems on the spot, they do trouble-shoot and present potential solutions.

Intimidating Behavior

One problem is that some employees can feel intimidated by physicians. Dr. Leggold points to one member of her staff who felt very uncomfortable whenever she asked her questions or approached her with constructive feedback about how to fix in-house problems. Now Dr. Leggold works through her office manager, who is used as a clearinghouse for all staff to avoid misinterpretations or nasty rumors from circulating throughout the office about new policies, procedures or staff.

She also suggests that physicians and office managers take some time to understand their employees' personal situations because they could impact their job performance. She recalls the time when some of her staff complained to her about changes that the office manager was making as well as his expectations of them. On one particular day, for instance, a receptionist was suddenly required to stay past five o'clock but was unable to do so. She says that the office manager complained that the employee was not going to work out. At that point, Dr. Leggold jumped into the conversation.

"I said, 'Do you understand that every one of these women who work at the front desk has a second job to feed her family,' and I explained what these women were doing to survive," she says. "He was flabbergasted. He didn't know that because he didn't talk to people and didn't know what they did."

Employees at Dr. Baum's office attend formal weekly staff meetings. At the beginning of each meeting, they take turns iden-

Survey: Workplace Intimidation Impacts Patient Safety

Intimidating behavior, a common element of many healthcare practice settings, may cause medication errors, according to a 2004 survey of more than 2,000 healthcare professionals, including nurses, pharmacists and other providers, conducted by the Institute for Safe Medication Practices (www.ismp.org).

Intimidating behaviors were not limited to doctors, the survey found, but physician/prescribers used condescending language or were impatient with questions twice as often as other healthcare providers.

Almost half of all respondents (49 percent) indicated that past experiences with intimidation altered the way they handled order clarification or questions about medication orders. At least once in the past year, about 40 percent of all respondents who had concerns about the safety of a medication order assumed that it was correct rather than interacting with an intimidating prescriber.

Survey respondents were asked how frequently in the past year they had encountered the following potentially intimidating behaviors by physician/prescribers:

	Often	Sometimes	Rarely	Never
Reluctance or refusal to answer your questions, return phone calls or pages	20%	40%	28%	13%
Condescending language or voice intonation	28%	39%	25%	7%
Impatience with questions	25%	41%	26%	7%
Strong verbal abuse	6%	16%	34%	44%
Negative or threatening body language	5%	15%	29%	51%
Reporting you to your manager (actual or threat)	4%	11%	27%	59%
“Just give what I/ the attending ordered.”	12%	25%	33%	31%
Physical abuse	0%	0%	4%	95%

Source: Institute for Safe Medication Practices.

tifying the best thing that happened to them or the practice that week so the meeting can start off on a positive note. Then a to-do list is created of what needs to be accomplished by the following week. A copy of the list is distributed to each employee within 48 hours so everyone has a clear understanding of what is expected of them.

Whenever job tasks are not being performed, employees should be given a chance to resolve the problem before pointing fingers. Not long ago, Dr. Baum walked by the patient's restroom at his practice and saw a huge mess. Toilet tissue was all over the floor, the waste basket was overflowing and urine in a specimen container had spilled onto the floor.

He showed his staff the mess and asked how many of them would want use the restroom. There were no volunteers. He said, "None of our patients would either." Then in a calm manner, he asked that this problem be placed on the agenda for the next staff meeting. Meanwhile, without any interference from Dr. Baum, the staff pitched in and cleaned the restroom.

"I'm not going to solve problems on the fly," he says, adding that whenever serious issues pop up, a meeting is held the next day to resolve it. "You do it when nobody is defensive and [everyone is] removed from the situation. Fine-tuning a practice is like raising children. You wouldn't tell them once a year at a performance review how they're doing. You would tell them on an ongoing, regular basis."