

Communicating With Patients From Check-in to Check-out

No one questions the importance of the clinical interview and the medical history that derives from that interview. It is estimated that 75 percent to 95 percent of the information needed to make a diagnosis comes from the patient-reported medical history.

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Physicians conduct between 120,000 to 160,000 interviews over the course of their careers. That’s more interviews than any clinical procedure. And while practice may make perfect, it helps to have a little theory and a framework to follow.

George Engel, the progenitor of the biopsychosocial approach to the medical interview (which has evolved into the patient-centered interview), compared learning how to talk to patients to

learning how to play a musical instrument. “What if music students were taught to play their instruments as medical students are taught to interview?” he wondered in a 1982 article in *The Pharos*.

Some music students who learn by ear become creative and accomplished musicians—often with an unconventional approach that is moving and effective. But others get no farther than picking out a simple tune on the piano, meeting with frus-

tration if they try something more complicated.

A similar phenomenon happens when medical students are taught to interview patients only by example. It leads to the “either-you-got-it-or-you-don’t” attitude towards patient communication. And it leaves some physicians without the advantage that training can provide.

“As you look at the history of the medical interview, it was considered to be bedside manner—something you had or you didn’t have,” says Richard Frankel, Ph.D., leading communications researcher and professor at Indiana University School of Medicine. “It was never taught formally. You just kind of absorbed by watching how your preceptors did their interview.”

But it turns out that medical interviewing is actually a set of skills that can be taught. And once absorbed and integrated into practice, these skills can result in better care.

Learning communication skills “is not about being a nicer doctor. It’s about being a better doctor,” says Dr. David Hatem, who practices internal medicine and serves as associate professor of clinical medicine at the University of Massachusetts Medical School in Worcester, Mass. “The way you talk to people will affect the type of information you get from them—which will affect your diagnosis.”

Clinical Interview Models

Evidence collected over the last 30 years of research into communications and the doctor-patient relationship has led to huge changes in medical school curriculum, including the development of models for the clinical interview. These models are now taught as part of communications courses. But physicians who have been out of school for more than 5 or 10 years may have received little formal instruction in this critical area of patient care.

“The whole field of doctor-patient communication has taken the quaint idea of bedside manner and converted it into a science of medical interview with the highest standard of scientific evidence, the randomized control trial,” says Dr. Frankel. “Now we know there are behaviors on the part of physicians that increase the probability of positive outcomes and, coming the other way, there are behaviors that physicians engage in that are associated with negative outcomes,” he explains.

Essential Elements of Physician-Patient Communication

Essential Element	Tasks
Establishes rapport	<ul style="list-style-type: none"> ■ Encourages a partnership between physician and patient ■ Respects patient's active participation in decision making
Opens discussion	<ul style="list-style-type: none"> ■ Allows patient to complete his/her opening statement ■ Elicits patient's full set of concerns ■ Establishes/maintains a personal connection
Gathers information	<ul style="list-style-type: none"> ■ Uses open-ended and closed-ended questions appropriately ■ Structures, clarifies and summarizes information ■ Actively listens using nonverbal (i.e., eye contact, body position) and verbal (words of encouragement) techniques
Understands patient's perspective of illness	<ul style="list-style-type: none"> ■ Explores contextual factors (i.e., family, culture, gender, age, socioeconomic status, spirituality) ■ Explores beliefs, concerns, and expectations about health and illness ■ Acknowledges and responds to patient's ideas, feelings, and values
Shares information	<ul style="list-style-type: none"> ■ Uses language patient can understand ■ Checks for understanding ■ Encourages questions
Reaches agreement on problems and plans	<ul style="list-style-type: none"> ■ Encourages patient to participate in decision to the extent he/she desires ■ Checks patient's willingness and ability to follow the plan ■ Identifies and enlists resources and supports
Provides closure	<ul style="list-style-type: none"> ■ Asks whether patient has other issues or concerns ■ Summarizes and affirms agreement with the plan of action ■ Discusses follow-up (i.e., next visit, plan for unexpected outcomes)

Source: *The Essential Elements of Physician-Patient Communication: Kalamazoo Consensus Statement, Academic Medicine, Vol. 76, No. 4, April 2001.*

In some ways, these communications courses (taken either in medical school or later as part of a continuing medical education requirement) are offered as antidotes to much of the standard medical school curriculum—courses and approaches that may actually lead to communication problems in actual clinical practice.

The medical interview is where the physician can get a glimpse of the psychological and social aspects of a patient's situation—the context for those signs and symptoms. But you have to know the right questions to ask and how to ask them in a way that elicits a complete response. Following an interview model can help you do that.

Take, for example, gross anatomy in the first semester of medical school. “The students’ very first introduction to a patient—their most intensive relationship with a patient at the beginning of medical school—is a dead patient, a cadaver,” says Dr. Frankel. “That teaches a kind of reductionism. What you’re learning from the cadaver is not what the patient was like during their life or who they were, but what the constituent parts of the body were.”

Although gross anatomy remains a first-semester mainstay, it is often now accompanied by a parallel course, sometimes called “Introduction to Clinical Medicine” or “Physicians and Society.”

“The idea is to pair the students’ experience with the cadaver with a live human experience,” says Dr. Frankel. “So if you’re working on the kidney, you bring in patients with kidney disease who can talk about the impact of the disease on their illness experience.”

This kind of course brings in the teachings of George Engel, who recognized that in order to treat the whole patient, physicians must consider the psychological and social influences on that person. This, Dr. Frankel says, is increasingly important as more and more patients deal with chronic illness, rather than acute disease.

“The vast majority of visits don’t deal with onset disease,” he says. “They deal with people’s concerns, people’s illness experiences. Yet when you look at the medical school curriculum, it still focuses largely on the biomedical.”

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uation—the context for those signs and symptoms. But you have to know the right questions to ask and how to ask them in a way that elicits a complete response.

And that’s where the idea of models comes in. Having a plan for the content and approach to the medical interview helps ensure that the physician covers the full gamut of the patient’s concerns. There are more than 18 different models available, but some of the most commonly taught are the Four Habits, SEGUE, the Macy Model, the 4 E’s and the Three-Function Model.

“The importance of a model is that it’s kind of a blueprint for a way of thinking,” explains Dr. Frankel, who developed the Four Habits model with Terry Stein, M.D., and Edward Krupat, Ph.D. “It’s not that doctors don’t care about the psychological and social well-being of the patient—it’s just not where their training takes them.”

Following a model has many advantages, doctors say. Dr. Hatem teaches the Three Function model in his Physician, Patient and Society Course for first- and second-year medical students at the University of Massachusetts, and he uses it with his patients.

“If I’m in an interview and it’s not going well, I can look back at the model and figure out where things went wrong,” says Dr. Hatem. “Learning a model gives me a systematic way to analyze what I did and did not do well.”

Using a model can also help the physician and patient set an agenda and keep the interview on track. And although following the steps of a model may take longer in some cases, it may actually make the interview more efficient, too. For example, covering the patient’s illness experience may add some time, but can give the physician a fuller picture of the person’s health and sit-

Three-Function Model

Developed by Julian Bird, M.D.

- Developing, maintaining and concluding the therapeutic relationship
- Determining and monitoring the nature of the problem
- Patient education and implementation of treatment plan

uation—which may lead to a treatment plan that is easier to adhere to. So the interview is longer, but covers more territory and yields a more effective plan of care.

But other interview skills, like upfront agenda-setting, can actually save time because physicians are less likely to get that hand-on-the-doorknob question that adds another five minutes to the encounter.

In any case, Dr. Hatem says, the final result is worth the effort of following a model. “It makes visits more complete,” he says. “And doctors and patients are more likely to feel good about the encounter.”

Until the 1970s there was no model for the clinical interview—the physician asked questions about signs and symptoms and tried to put it all together to come up with a diagnosis. As a result of the explosion of research into physician-patient communications over the past three decades, now there are at least

The SEGUE Framework

Set the Stage

1. Greet patient appropriately.
2. Establish reason for visit.
3. Outline agenda.
4. Make a personal connection during visit (go beyond medical issues).
5. Maintain patient’s privacy.

Elicit Information

6. Elicit patient’s view of health problem and/or progress.
7. Explore physical/physiological factors.
8. Explore psychosocial/emotional factors.
9. Discuss antecedent treatments.
10. Discuss how health problem affects patient’s life.
11. Discuss lifestyle issues/prevention strategies.
12. Avoid directive/leading questions.
13. Give patient opportunity/time to talk.
14. Listen. Give patient undivided attention.
15. Check/clarify information.

Give Information

16. Explain rationale for diagnostic procedure.

18 different models for the clinical interview.

“There’s no one agreed-upon standard,” says Dr. Frankel. In 1999 the Institute for Healthcare Communication and the Fetzer Institute brought together experts in communication to come up with a list of “essential elements” of the medical interview. The idea was to come up with a common framework for medical-school curriculum and professional standards (*see box on page 35*). But the resulting “Kalamazoo Consensus Statement” hasn’t been the last word.

“The science of the medical interview is young and growing,” says Dr. Frankel. “If you were to think about it in terms of how scientific discovery moves forward, we’re in the early part of recognizing what the very best practice may be.”

But there’s definitely consensus developing.

“If you look at the various models, there are more similarities than differences,” says Dr. Hatem. “At this point, the most impor-

17. Teach patient about his/her own body and situation.
18. Encourage patient to ask questions/check understanding.
19. Adapt to patient’s level of understanding.

Understand the Patient’s Perspective

20. Acknowledge patient’s accomplishments/progress/challenges.
21. Acknowledge waiting time.
22. Express caring, concern, empathy.
23. Maintain a respectful tone.

End the Encounter

24. Ask if there is anything else patient would like to discuss.
25. Review next steps with patient.

If suggested a new or modified treatment/prevention plan:

26. Discuss patient’s expectation/goal for treatment/prevention.
27. Involve patient in deciding upon a plan.
28. Explain likely benefits of the option discussed.
29. Explain likely side effects of the option discussed.
30. Provide complete instructions for plan.
31. Discuss patient’s ability to follow plan.
32. Discuss importance of patient’s role in treatment/prevention.

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tant thing is to choose a model and to teach it consistently and to nest tasks within that model.”

Models Feature Common Elements

“It comes down to some very basic skills,” says Kris Baird, R.N., practice management consultant with Baird Consulting in Fort Atkinson, Wis. “You have to pack a lot in, in a short period of time. Some of the basics are establishing trust, connecting with the patient on their agenda not yours, then really engaging, summarizing and following up. Those are some of the most important features.”

Most of the communication models include the following common elements:

■ **Focus on the patient/involve the patient.** There are two types of information that must be gleaned from the medical interview: patient-centered information and doctor-centered information. The best place to start is with the patient, and the best way to get the patient to open up is to establish rapport.

The basis of this rapport is in the medical chart or, in the case of a new patient, on the office notes from the receptionist and/or nurse. Instead of entering the room with eyes glued to the chart, Dr. Frankel suggests that physicians review it beforehand.

Electronic medical records can make this even easier. Recently, Ms. Baird accompanied a relative to the Mayo Clinic for an appointment. Every member of the team—from the recep-

tionist to the nurse to the physician—had checked the EMR before talking to the patient. They knew the patient’s diagnosis, where she had traveled from and the purpose of the appointment. “The doctor didn’t have to say, ‘What brings you here today?’” recalls Ms. Baird. This helps give the staff an immediate head start on building rapport.

In addition to checking the chart, Ms. Baird also recommends taking a deep breath before walk-

The 4 ‘E’s

The Institute for Healthcare Communication uses the structure of the 4-E’s in their communication courses for clinicians:

- Engage
- Empathize
- Educate
- Enlist

ing into the exam room. “That almost forces you to slow down,” she says. It’s hard for a patient to become engaged with someone who is in a hurry.

Then put the chart by your side and walk in. “If the chart is right in front of you,” says Ms. Baird, “the temptation will be to look down at it. Get it out of your line of sight. Sit down next to the exam table or side-by-side.” The medical interview is an important conversation—and important conversations rarely take place with a hand on a doorknob or eyes on a piece of paper.

If the patient has had to wait, that’s all the more reason to slow down. He or she has been waiting for the doctor’s attention; now it’s the doctor’s turn to follow through. Experts agree that the physician should acknowledge and apologize for the wait, but also assure patients—both verbally and nonverbally—that their visit will not be compromised because the office is behind schedule.

“For the first few minutes, just listen,” encourages Dr. Frankel, whose research shows that physicians tend to interrupt patients within the first 18 to 21 seconds. This can lead to missing important information—and also missing a great opportunity for building rapport.

Physicians may worry that letting the patient do the talking may eat up too much of the allotted time. But studies show that if allowed to speak uninterrupted, patients will take about a minute and a half to explain their concerns, and in that time they may give physicians key information that will allow them to zero in on the chief complaint.

Besides, Ms. Baird says, “There’s no greater gift than your attention in demonstrating respect for another human being.”

In return, the physician gets a gift, she points out: the illusion of more time. Ms. Baird cites studies that show that patients perceive that their visit is longer when the physician sits down and makes eye contact rather than standing by the door or looking

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mostly at the chart or acting as if he or she is in a hurry.

Dr. Frankel points out that opening up a dialog and encouraging questions can make the medical interview more efficient and effective and may save actual time, in addition to giving the perception of more time. In a series of studies by Dr. Sheldon Greenfield, patients were coached to ask more questions and be more proactive bringing up concerns during the medical interview.

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“A lot of doctors think they have to control the medical interview because if they don’t, time will get away from them,” Dr. Frankel says. “But [Greenfield and colleagues] found that it didn’t take more time when

patients asked more questions.” In fact, he says, it took less time.

“When you think about it, it actually makes sense,” he continues. “If you know what’s on my mind, you can be more efficient than if you’re asking questions all over the place to try to figure out what’s going on.”

■ **Set the agenda with the patient.** The key here is that this is a joint effort between the physician and patient—a give and take that’s ultimately going to lead to a treatment plan that the patient can adhere to.

Setting the agenda up front also is the best defense against one of physicians’ greatest frustrations with medical interviews: the “hidden concern” that emerges in the last moments of the encounter and adds minutes to the visit.

When the physician interrupts just 18 seconds into the interview, “the doctor starts solving that problem, not realizing it’s not the main problem,” says Dr. Frankel.

So what should a physician do? Experts agree: You should ask,

“What else?” and continue to ask, “What else?” until the patient finally says, “That’s it.”

“If the patient has a long list—say five or six things—you might ask them to pick the two or three that are their top priorities, then suggest another appointment to discuss the others,” recommends Dr. Hatem.

Open-ended questions can help the physician get to the root of the patient’s concerns and focus on those things. But that doesn’t mean the physician ignores his or her own concerns. For example, if the patient comes in for recurrent headaches, the physician may recognize that the patient also has a weight problem or a smoking habit that may actually be a greater health risk for that patient. Perhaps the headaches could be the hook that gets the patient to pay attention to other health issues.

Here’s where it can help to take a page from the marketers’ manual. Salespeople have long realized that in order to sell their product, they must appeal to what the buyer is looking for. And

The Four-Habits Approach to Effective Clinical Communication

Habit 1: Invest in the Beginning.

- Create rapport quickly.
- Elicit patient’s concerns.
- Plan the visit with the patient.

Habit 2: Elicit the Patient’s Perspective.

- Ask for patient’s ideas.
- Elicit specific requests.
- Explore the impact on the patient’s life.

Habit 3: Demonstrate Empathy.

- Be open to patient’s emotions.
- Make at least one empathic statement.
- Convey empathy nonverbally.
- Be aware of your own reactions.

Habit 4: Invest in the End.

- Deliver diagnostic information.
- Provide education.
- Involve patient in making decisions.
- Complete the visit.

while physicians aren't selling a product or service, Ms. Baird points out, they are promoting a healthier life for their patients. To do that, she says, "You have to look at what is important to the individual. Patients are going to connect with what they value. So it's not the provider's agenda. You need to know what the motivator for the patient is."

■ **Show empathy.** In the fast-paced world of medicine, it can be difficult to slow down enough to recognize and acknowledge a patient's emotions. But studies indicate that showing empathy takes only a minute and can make a world of difference to both physician and patient.

The first challenge is that patients don't always overtly show emotion. The patient who says, "My daughter is moving out of state," may do so matter-of-factly, without revealing the pain that this separation may cause her. If the physician ignores this potential concern, the patient may become only more upset—and may blurt out the concern at the end of the visit, just as the physician is ready to move on to the next patient.

Instead, experts recommend exploring the potential for emotion around the issue. In the Four Habits model, Dr. Frankel and colleagues recommend using "open-ended continuers," such as "Go on" and "Tell me more," to see if the patient wants or needs to talk more about the issues. Then move forward with a more specific question: "Is there something in particular that scares you?"

At that point, the patient may admit that she's afraid that her health problems may prevent her from visiting her daughter in her new home.

Possible responses that show empathy might include these phrases:

- ▶ I can see that you are... (shows reflection).
- ▶ I can understand why you feel... (legitimizes emotions).
- ▶ I want to help (shows support).
- ▶ Let's work together (shows partnership).
- ▶ You're doing great (shows respect).

While empathy may not seem like a medical issue, it has important implications for both doctor and patient: Physicians who show empathy are less likely to be sued for malpractice, and their patients are more likely to follow their recommendations.

■ **Be explicit.** Most patients face a visit to the doctor's office

with a bit (and sometimes a lot) of apprehension. It can feel like surrendering yourself to someone else's process. The jargon, the procedures, the policies can all seem foreign and off-putting. Even highly educated patients can feel helpless and confused when confronted with the healthcare system.

To help patients navigate their part of the maze, physicians need to be explicit—taking the time to orient the patients to the process. Dr. Frankel suggests using language that lets the patient know what the physician is doing: “I’m going to take your blood pressure now,” “I’m going to make some notes on your chart.”

After the physician collects information and examines the patient, he or she must deliver the diagnosis, cause, treatment choices and time frames for choices. That's a lot of information, and it can be really important information. Using the teach-back method can help ensure that the patient understands.

It also helps for the physician to explain his or her line of thinking when asking follow-up questions. Dr. Hatem uses the example of a patient who comes in with diarrhea. Because the doctor thinks it may be inflammatory bowel syndrome, he or she may ask about family history. But the patient may not understand why they're suddenly talking about his parent's health when he came in for what looks like an acute condition. “The patient sees the questions as an interruption,” says Dr. Hatem. “They don't see the connection. Explain your thinking, and they'll follow you better.”

It pays to be explicit in a larger sense, too, in treatment decisions and qualifications of physicians. Martie Moore, R.N., senior vice president of patient services at MaineGeneral Health, a network of healthcare facilities in the Kennebec Valley, recalls a patient who was hesitating about going ahead with treatment. By exploring the root of the hesitation, Ms. Moore discovered that the patient was concerned that he might get better care if he went to a big city medical center. Once she understood this, Ms. Moore was able to assure the patient that MaineGeneral followed the same standards of care as the big city hospital, that the physician in charge of care was highly trained and that the recommended treatment was evidence based. If the physician had

explained the basis for the recommended treatment, the patient would have felt reassured from the beginning.

■ **Teach back/check understanding.** Another key to a successful encounter is to check the patients understanding using the “teach-back” method. After the physician collects information and examines the patient, he or she must deliver the diagnosis, cause, treatment choices and time frames for choices. That’s a lot of information, and it can be really important information. Using the teach-back method can help ensure that the patient understands.

“Break the information down into smaller bits, and check in after each bit,” says Dr. Hatem. “You can say, ‘We just went through a lot of information. Can you explain back what I said so I’m sure we’re on the same page?’”

The reverse is also true. If the patient has just explained a list of concerns about treatment, the physician can check his or her own understanding by saying, “There’s a lot on your mind today. What I’m hearing is that you’re concerned that you are very tired lately and you’ve been having headaches...” If the patient is actually more concerned about something else, the physician has offered an opportunity to correct the information.

It may take some time to integrate these skills into practice, but the results can be medical encounters that get better results for both physician and patient.

The Patient’s Perspective

Communication with your patients starts long before the patient interview, however. From the moment the patient hears of your practice, he or she begins forming an impression of what the practice is like and how he or she might benefit from making an appointment. That impression builds over the telephone, in the waiting room, in the exam room and back at the front desk at checkout. And while the physician may not have complete control over the whole process, chances are there is much the physician can do to improve it.

Physicians don’t always think of the total package of how a practice communicates, says Dr. Hatem. They think of their individual relationships with patients. But, the patient’s experience with every aspect of the office can color that relationship. “Physi-

cians need to think of how the office as a whole communicates,” he says. “This will become more and more important as patient-satisfaction data become tied to individual physicians.”

That’s because patient-satisfaction surveys are now digging

Everything Speaks

Practice consultant Kris Baird, R.N., tells her clients, “Everything speaks.” She explains that everything patients see and experience as part of seeing their doctor helps form an overall view of the practice. She asks doctors, “If everything speaks, what does your practice environment say about you?” Here are some of the things she sees and what might run through a patient’s mind when he or she sees them:

What Your Patient Sees

What Your Patient May Think

Dead flowers in the planters in front of the office

Uh-oh. These folks are not good with living things.

Security post with no security guard

This building has a security problem, but no one is doing anything about it.

“For Physicians Only” parking places located right by the door to the building while the handicapped parking is around the corner

The doctors think they’re more important than the patients.

Television, recipe cards and other elaborate activities available in the waiting room

I’m going to be waiting a looong time.

Outdated magazines in the waiting room

They haven’t cleaned this place in a while.

Stacks of charts and other clutter

Are they going to lose my chart?

Scale in the middle of the hallway

If they don’t mind broadcasting my weight, is the rest of my medical information confidential?

Paper signs taped up in the bathroom and hallway

These people don’t take the time to communicate effectively.

Staff gossiping behind the desk

What are they going to say about me when I leave? *Or* Is that my doctor they’re talking about?

deeper into patients' views on specific parts of their healthcare visit. It's not just "Do you like your physician?" Most people will answer "yes" to that question. But, when the questions get more specific—such as "Did your doctor answer all of your questions?" or "Was the staff courteous and helpful?" or "Do you feel the staff did everything to control your pain?"—then patients tend to voice specific shortcomings in the system.

And patients see the whole medical office as part of one big picture. The doctor is a large part of the picture, but everything—from the availability of parking to the ease of making a follow-up appointment—colors the patients' view of that practice. While most of the research on communications and health has focused on the physician-patient relationship, there's a growing realization that the quality of that relationship—while incredibly important—can only go so far if the patient doesn't also have the opportunity for a supportive relationship with the physician's practice, local health resources and even the healthcare system as a whole.

First Contact

Dr. Frankel explains it this way: "If you have a 90-year old who uses a walker and has to park a quarter of a mile away and walk up a flight of stairs because there isn't handicapped access, by the time she gets to the physician she's already had so many negative experiences the physician would have to be a god to overcome them."

That may be an extreme example, but it shows just how much can go wrong before the patient even shakes hands with the doctor. And, although the physician is not directly involved in these transactions, they reflect back on him or her.

So the doctor has to get involved, says Ms. Baird. "In small practices, the physicians have to get engaged. This is their business, and they have to make it as seamless as possible." In larger health systems, physicians need to be an advocate for the patient's experience. "Physicians have to make their voices heard," she says.

Dr. Frankel recommends applying the "Ritz-Carlton" philosophy to the medical practice by working as a team to make the patient the center of the healthcare experience. "If I'm a mem-

ber of a team and the customer is at the center and the customer's loyalty depends on every member of the team, then we're all in this together," he says.

Ms. Baird suggests that the practice set as part of its mission that "every patient who comes in contact with this organization is going to come away better informed than when they walked through these doors," she says. "Every healthcare encounter can accomplish this if everyone buys into it."

Ms. Baird encourages physicians and their staff to "put your head into the space of the new patient." In fact, she offers a service to her clients called "Secret Shopping," in which she poses as a patient and puts herself through the whole process of making an appointment and seeing the doctor (*see box on page 51*).

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"We think of it as the patient experience pathway, Ms. Baird explains. "We want to experience the encounter to duplicate how a potential customer would come in contact with the practice."

She starts where the patient might start—with an ad in the Yellow Pages or a practice Website. She looks at the information and how it's presented. "What does the Yellow Pages ad say? Does it give any indication of what the practice is all about? How well does the Website communicate? Does it talk about the philosophy of care? Does it give the hours?"

Then, she picks up the phone and dials the practice number. She notes whether she gets a human being at the other end of the line or a phone tree. Patients might reluctantly accept the idea of an automatic answering service and a phone tree, but they certainly don't like it. It can send a mixed message: If this is a human business, why doesn't a human answer the phone?

And, even if phone trees are a necessity these days, some setups are better than others. For example, how many buttons do you need to push to get to a human? How long do you have to wait for someone to pick up? If there is no one available, can you

leave a message or are you told to call back? Ms. Baird says that many systems don't seem to take into account what patients are looking for. For example, she tells of one practice's phone-tree message that gave her options to refill a prescription, talk to the secretary or talk to the nurse, but no option for making an appointment. When she hesitated before choosing an option, the system said, "I'm sorry, I didn't understand your response. Please call back later." Click.

"Am I irritated already?" she says, "Do you see how many impressions I've had and I haven't even had the phone answered?"

Never mind the public-relations implications; there are practice-management implications for this too. There is no way to track the calls that didn't go through. And a patient—or a referring physician—who gets irritated is not likely to try a second time.

When the phone is answered, it's important that the person answering reaches out beyond the office to the patient's line of thinking. "It's not about your jargon internally, it's about what the patient hears," says Ms. Baird.

For example, what does the receptionist say when a patient asks for an appointment with a doctor who is not taking new patients? Practice-management jargon may be "That practice is closed," but a patient will think the physician is no longer practicing medicine. A better answer would be, "Dr. So-and-So is not currently taking new patients, but he or she has a highly qualified partner, and that physician has appointments next week. Is there a day that would be good for you?"

Waiting Room

Most patients spend more time in the waiting room than in the exam room, but few practices really think through how patients experience that time. Just set out some magazines and you're done, right?

Actually, patients don't expect entertainment while they wait. They expect to see their doctor within a reasonable amount of time—maybe 20 minutes. (It varies by region and even by age group, says Ms. Baird; older people are more willing to wait than younger ones.) Up-to-date magazines can help pass the time (out-of-date ones show that no one has maintained the room).

But there is much more that can be done to improve this important chunk of time.

In most practices, the front desk is a busy place. The person sitting there is meeting and greeting patients, answering phones, scheduling appointments, handling insurance co-pays and checking out patients. “It becomes a zoo,” says Ms. Baird. And, it’s a real problem, in terms of customer service, confidentiality and public relations.

“It’s amazing how much you can overhear [as a patient in the waiting room],” says Ms. Baird, remembering how she overheard staff comparing the surgical skills of a couple of physicians. “The staff is basically on stage,” she says. “They have to have

Put Yourself in the Patients’ Shoes

When Kris Baird, R.N., of Baird Consulting, is hired by a medical practice or other healthcare provider, she does a comprehensive assessment of that practice: she looks at satisfaction data from patients, employees and physicians. “That paints a picture of a culture,” she says. She also holds focus groups with patients and staff and interviews the executives. But even with all that information, she says she often has trouble “connecting the head to the heart.”

That’s when Ms. Baird starts “Secret Shopping,” posing as a patient to get a clearer picture of what a practice is really like.

“You can’t argue with someone who says, ‘This is what happened,’” says Ms. Baird. “When I say, ‘Here’s what I found when I walked into your building, this is how I was greeted by your staff or this is what happened when I called to make an appointment,’ you just can’t explain that away.”

It can be a huge eye-opener. “There are times when physicians are ready to fall off their chairs when I tell them what happened,” she says.

A similar thing can happen when a physician becomes a patient and has to experience the system from the other side. “The more I look at healthcare in general, the more I think it is a very complicated system that we’re very used to being part of,” says Dr. David Hatem of the University of Massachusetts. “We don’t explain enough to patients. It’s often not completely clear to patients at a very basic level. Who are all these people? Who’s in charge? Who’s making the decisions? It only takes a physician to get sick, and all of a sudden there’s this insight into what patients are talking about.”

360-degree vision and to think about what the patients are hearing, seeing, feeling and smelling.”

Her first recommendation to practices is often to remove all ringing phones from the front desk. Even discharge can be moved to the exam room, allowing the person behind that desk to focus on just the patients in the waiting room. That way, if a patient needs help filling out a form, the front-desk person is more likely to be able to answer the question quietly and confidentially. The staff can also keep track of wait times and keep the patients informed of progress or delays.

First impressions mean a lot, but the last impression is what the patient takes with them. It's important that patient understand instructions and what to expect next. If there are lab results, whose responsibility is it to follow that up? Is another appointment needed? Does the patient have any questions about the prescriptions or other procedures?

She also suggests having a “service recovery plan” in place in case the physician gets called out on an emergency. A simple plan is to give patients the option to wait, reschedule for another time or to see another physician. If they choose to wait, an offer of a glass of water can send the message that “We’re going to take good care of you.”

Ms. Baird adds: “The thing about life in general and customer service specifically is that you get a lot further with basic good manners: please, thank you, and I’m sorry.”

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“The biggest thing a clinic can do is close the deal,” says Ms. Baird. “Whoever is ending that clinic encounter needs to recap what to expect.” The discharge person should go over how that patient wants to be informed of lab results and the best time and place to call with those results.

Even then, the encounter is not really over. Many health professionals are finding that callbacks make a huge difference in

terms of adherence, continuity and satisfaction.

“It doesn’t need to be the doctor,” says Ms. Baird. She suggests that a nurse or other trained staff person follow up with a phone call when a patient is very sick or there is a new diagnosis or change in medication. Just checking to see how the patient is feeling or if he or she has any questions can convey the doctor’s concern for the patient and help ensure that the patient is on track with the recommended treatment. “It takes only a few minutes to really improve customer satisfaction,” says Ms. Baird.

Who’s on the Team?

Effective communication goes beyond the physician-patient interaction. Your staff and other providers caring for the patient need to communicate along the same lines. According to a recent survey of physicians by the Commonwealth Fund, 87 percent of primary-care physicians think that improved teamwork and communication among providers would improve quality of care. But often communication between team members isn’t as clear as it should be, and “team” means different things to different team members.

“It is completely transparent [to the patients] when the physicians haven’t talked to one another or the physicians and nurses haven’t communicated,” says Ms. Baird. “When they see that, their level of confidence in the care deteriorates tremendously.”

Other industries have been making their communication clear for years. From short-order cooks to air traffic controllers, co-workers are trained to repeat and repeat back orders to make sure everyone is getting the same message.

“In medicine, we’ve been kind of slow in figuring that all out,” says Bradford W. Hesse, Ph.D., chief of the National Cancer Institute’s Health Communication and Informatics Research Branch. “But if you have a team that checks every step of the way, you ratchet down medical errors, and you get a system that’s more responsive to patients’ needs. And you get patients that are happier and healthier.”

Here’s a look at who’s on the team and how other team members may perceive them:

■ **Physician.** “The physician used to be seen as the captain of the ship,” says Ms. Moore of MaineGeneral. Now, she says, the

analogy is more like the quarterback of a football team. “There’s a playbook, and everyone plays a role.”

Dr. Frankel compares this change to the transformations that took place in the aviation industry in the late 1970s and ‘80s. In the first years of air travel, he says, “the pilot had complete control and complete responsibility.” As a result of research into the cause of air accidents, the concept of Crew Resource Management was introduced in 1979. “The idea is to move from a vertical hierarchy to a horizontal relationship and from a group of individuals to a crew that works together as a team,” Dr. Frankel explains.

But that has been a tough switch in medicine.

“Physicians get a different message,” says Dr. Hesse. “They hear, ‘You’re responsible for everything.’” That message comes loud and clear from a legal system in which patients sue individual doctors when something goes wrong. Physicians are also hailed as the hero when all goes well. But the reality is that systems work best when team members realize they’re all in this together, and the physician isn’t out there on his or her own.

“It takes recognizing that it’s not just me,” says Dr. Frankel. “It’s recognizing that we’re all in this together. But then I think the opportunities for improvement are dramatic.”

■ **Nurse Practitioner or Physician Assistant.** Teamwork is an integral part of the training of these healthcare professionals. Working collaboratively with physicians is a normal way of working for them. But this may not be as clear to patients who don’t see the regular consultations that take place with the doctor. According to a recent internal study done by Harvard Vanguard Medical Associates, patients are most pleased when they see their own physician. Seeing the physician’s assistant or nurse practitioner who is part of the healthcare team was no more satisfactory to patients than seeing a completely different provider.

“The question that raises for me is, ‘How was that hand-off made?’” says

Dr. Hatem.

“How explicitly are people making that team connection?”

Dr. Hatem

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says he works hard to make it clear that the nurse practitioner in his office is on the same team. “I say, ‘My nurse practitioner will see you next month and report back to me. I’ll check you the month after that.’”

■ **Nurse.** Nurses are also accustomed to working collaboratively, and patients usually perceive nurses as working together with the physician. In fact, patients can sometimes get frustrated when they’ve repeated the reason for their visit three times before they even see the doctor—once on the telephone to make the appointment, once at sign-in and again to the nurse. “If nurses and doctors work together, then why does the physician ask me the same question? Aren’t these folks talking to each other?”

The nurse’s role may actually become more important as patients need help sifting through all the information they read on their own and their physicians’ recommendations. Some health-care organizations now have “advice nurses” whose primary role is to answer patients’ questions and fill in gaps that the physician couldn’t address in a 15-minute patient encounter.

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■ **Consulting Physicians.** Especially in complicated cases—cancer particularly—or in the case of chronic illness, multiple physicians are often working with the same patient. These doctors may not be in the same practice, the same hospital or even the same city, but they’re still on the same team. For example, if a patient decides to seek out a cancer specialist at a specialty center, consulting physicians may have to maintain long-distance relationships to ensure continuity of care. Ms. Baird emphasizes the importance of having a system to deal with referrals and make sure there’s a free flow of information. It not only makes good medical sense, she points out; it makes good business sense. “You need excellent communications because people are going to not want to send you referrals if you don’t communi-

cate back to them,” she says.

■ **Front Desk.** The people at the front desk may not be trained healthcare professionals, but they’re very much a part of the team in the patients’ point of view. They are the ones who see the sick patient come into the waiting room. If they are also answering phones, they have heard the reason for the visit. They take the insurance information and find the medical record. They are also the ones who schedule follow-up appointments, call prescriptions in to the pharmacy and say good-bye to the patient. So they are the ones who provide that last—and lasting—impression.

If the first principle of patient-centered care is to be respectful of and responsive to individual patient preferences, needs and values, then certainly the patient is part of the team. “Sometimes we think we know more about the patients’ health than they do,” says Martie Moore, senior vice president of patient services at MaineGeneral, “and that’s not true. We have to partner with them.”

While the patient is quick to see the front desk as part of the team, physicians may not see it that way at first. Dr. Hatem

admits that there was a time when he joined in when a patient complained about the long wait for an appointment or the surliness of front-office staff. But now he realizes that patients see the physician and the front office as all parts of the same whole.

“They look at the M.D. as the one in charge, and when the doctor expresses his frustration, they’re thinking, ‘What’s going on here?’” Dr. Hatem says. “Our staff is our staff, and we have to think about it that way.”

Joining in complaints about other aspects of the practice reflects poorly on the team as a whole. “It is probably misplaced for me to vent my frustration [in front of] the patient because I want to be part of the solution,” he says. “Because the truth is, if they’re running late out front, I’m not going to be satisfied, either.” The staff has to work together to streamline the process.

“Your staff are going to be reinforcing information and supporting you in your endeavors,” says Ms. Baird, emphasizing the importance of working together and keeping lines of communication open.

Dr. Frankel says that the best approach is to bring the office

team together and say, “We’re getting reports from patients that they’re having difficulties with the front desk. How can we work together to improve the situation?” It has to be done in the context of learning and not blame, he says.

■ **Patient.** If the first principle of patient-centered care is to be respectful of and responsive to individual patient preferences, needs and values, then certainly the patient is part of the team.

“Sometimes we think we know more about the patients’ health than they do,” says Ms. Moore, “and that’s not true. We have to partner with them.” She gives the example of the patient who uses herbal remedies as well as conventional medicine. That patient may have information that the physician is not familiar with. By working together to answer questions, physician and patient can exchange valuable knowledge about an herbal preparation, its benefits, side effects and possible interactions.

All the team members—from front desk to physician—need to engage the patient in the process. “People have to feel not only that you elicited their opinion, but also that you’ve included that in coming up with the treatment plan,” says Dr. Hatem. “The patient may not expect a treatment plan from the front desk, but they do expect courtesy.”

A prime way to meet that expectation is to make sure the patient knows where he or she is going and what the next step is.