# Skills Training in Communication and Related Topics

## PART 2:

COMMUNICATING WITH PATIENTS, COLLEAGUES, AND COMMUNITIES

ELLEN J BELZER

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TRAINING TOOLS FOR HEALTH PROFESSIONALS

# Skills Training in Communication and Related Topics Part 2

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## Communicating with patients, colleagues, and communities

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# Contents



## BY ACTIVITY

### EFFECTIVE LISTENING

Dedication

The *Skills Training* series is dedicated to the memory of my dear friend and mentor
R. Michael Miller

# About the author

**Ellen J. Belzer, MPA**, is president of Belzer Seminars and Consulting, LLC, a Kansas City, Missouri-based company specializing in negotiation, management, and communication programs and services for health care professionals. For more than 20 years, her seminars have been conducted for many thousands of health care professionals throughout the United States. In addition to serving as a professional mediator and organizational consultant, she frequently facilitates strategic planning and brainstorming sessions for public and private sector health care organizations. Prior to starting her seminar and consulting practice in 1986, she was an executive at a national medical specialty society for 12 years where she received a broad background in medical socioeconomics.

Ellen currently serves on the adjunct faculty of the dispute resolution programs at Baker University and Johnson County Community College, both in Overland Park, Kansas. She previously served as a communications instructor at Avila University in Kansas City, Missouri, and also taught negotiation and leadership development courses for the University of Kansas. She received her BA degree from Northwestern University in Evanston, Illinois, and her Masters of Public Administration degree from the University of Missouri at Kansas City. She received additional training in negotiation from intensive programs at several leading universities in the United States.

# Introduction

The fact that you're even perusing this book says a lot about you. You want to improve communication skills among your medical students, nursing students, public health students, residents, colleagues, employees, or others. You realize that people retain more when they **learn by doing**, and also know the importance of adding variety and spice to your training sessions. Whether you're teaching a class, in-service, noon conference, workshop, seminar, or any other form of training, you want each program on communication and related topics to be relevant and engaging for participants – perhaps even fun.

Those are the reasons why the *Skills Training* series was developed. It's designed for faculty members, practice leaders, hospital leaders, and public health professionals who want to help health care professionals upgrade their communication skills in a time-efficient manner. It's to help you – the instructor – save time when developing courses, while enabling your learners to practice and refine their skills in a safe learning environment.

There's another reason this series was developed – and that's my not-so-hidden agenda.

For more than 20 years, I've been traveling around the United States conducting seminars and conflict mediations for various types of health care professionals in practices, managed care organizations, hospitals, rehabilitation facilities, medical and nursing associations, and other types of health care settings. Throughout these years, I've seen too many unnecessary conflicts among health care professionals that developed as a result of faulty communication. There are too many disputes between and among the myriad disciplines, professions, and specialties that comprise health care: doctor versus doctor, doctor versus nurse, nurse versus physician's assistant – and everybody versus the administrator. There are far too many lapses in communication, too many silos dividing divisions or departments, and too many power struggles.

In short, there's too much "them-us" in health care – an anomaly because health care is an industry that, by all rights, should be among the most harmonious!

Perhaps the magnitude of the "them-us" syndrome should not be surprising. Although high-level communication skills are expected of every health care professional, these skills have been woefully under-taught. In many health professions, communication skills, and related topics have taken a backseat to clinical topics (which is understandable, but not an excuse to ignore these vital skills) and have fallen victim to the stresses and pressures of today's precarious economic and social-political environment (still not an adequate excuse for giving short-shrift to communications training).

Still, there's great reason for optimism. The Accreditation Council of Graduate Medical Education (ACGME) requires training for residents in interpersonal communication and

professionalism. And many residencies, medical schools, nursing schools, and schools of public health as well as continuing education programs for all types of health care professionals recognize the need to offer training in these important subjects. It is my hope that the tools in this series will help to encourage this type of training even more.

Within the three volumes in this series, you'll find hundreds of group involvement activities: icebreakers, worksheets, introductory discussions, case studies, demonstration exercises, role plays, and self-tests. This book (Part 2) contains training exercises on communicating with patients, colleagues, and communities. Part 1 is devoted to topics that will enable your trainees to deal more effectively with conflict and change, and Part 3 addresses leadership/management and organizational skills. I hope you'll utilize the entire series – not only to maximize your training options – but also because each of the 27 topics addressed in the three volumes is relevant to situations that your trainees currently face (or will face) every day. Each is important to learners' mastery of these vital topics.

Here are some tips on using the *Skills Training* series.

- Scan through the table of contents to find the section(s) you plan to teach.
- Select the exercise(s) that best fit your topics and available training time.
- If indicated in the instructions, make copies of training exercises you have selected.
- Prepare a brief lecture on the topic.
- Follow the instructions for processing the exercise.
- Utilize the tips at the end of this book to constructively critique participants as they build their skills.
- Encourage trainees to present their observations, insights, and "aha" moments as well.

It's that simple, and the results are well worth it. Quality communication contributes to smoother running practices, better care and services, greater efficiencies, fewer unhealthy conflicts, more satisfied staff and patients, and an improved ability to meet the challenges of an evolving and increasingly complex health care environment. My wish is that you, your trainees, and your health care organizations achieve these dividends – and more.

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Because numerous exercises in this book were originally published in *The Health Care Collaborator* (HCC), an online newsletter that I published from 2000–03, I extend my thanks to members of the HCC Board of Advisors (in alphabetical order): Bruce Bagley, MD; Helen H. Baker, PhD, MBA; Stephen Brunton, MD; Angeline Bushy, PhD, RN, CS, FAAN; Gregory Carroll, PhD; Kevin Fickenscher, MD; Steven P. Geiermann, DDS; Romeo J. Guerra, MA; Charlotte L. Hardt, BSN, MSHA; Molly Hartshorn, MSHP, CMPE; A. Clinton MacKinney, MD, MS; Ross P. Marine, DHL, MHA; Lee N. Newcomer, MD; Dave Palm, PhD; Patrick L. Patterson; Michael P. Rosenthal, MD; Roger A. Sherwood; and Donna M. Williams.

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Last but not least, thanks to the many thousands of participants in my training programs and mediations over the past 20-plus years that provided the field testing for many of the training tools you'll find in this book as well as in Parts 1 and 3. – EJB

# Using this book

Let's begin by addressing some of the questions you may have about using the training material in this book.

**Can I make copies of the handout material provided in this book?**
Yes! Handouts for participants are contained on separate pages following the instructions. The handout material is also available at www.radcliffe-oxford.com/trainingtools

**Can I modify the exercises?**
If you don't want to use these exact exercises, feel free to modify them to fit your particular training needs. Even if you don't use the exercises in this book, it is hoped that you can get ideas from them.

As a word of caution, however, don't be too quick to make changes that would homogenize the role-play exercises by changing the characters to persons in your field alone. If some learners balk at the idea of playing the role of someone from a different profession or discipline, encourage them to stretch. There's a great deal of learning in trying to see things from someone else's window on the world.

**Other than the exercises, what should be the content of the training sessions?**
Begin each session with a brief lecture on the topic you're teaching so that learners will be able to practice new strategies. While this book provides activities that will enliven your training, your course design and content is up to you. Refer to the reading list at the end of the book for resource material.

**What are the special features of this book?**
Three matrices at the end of this book will help you determine which exercises best meet your specific training needs. Matrix 1 shows which exercises are recommended for each training topic; Matrix 2 identifies which exercises are best for persons in various types of health professions; and Matrix 3 identifies each exercise by length so that you can select those that best fit into your available time slots.

The appendices also contain tips for trainers, suggestions on managing the critique sessions that you will conduct after the exercises, and a sampling of quotations about each of the suggested training topics to add pizzazz to your training programs.

**How accurate are the suggested training times?**
Times have been estimated for groups of 15 or fewer. For training programs involving more participants, add extra time for group reporting and discussions.

# Definitions

### ICEBREAKERS

These are warm-up exercises that introduce the topic, create interest in the subject matter, and set the stage for group involvement.

### INTRODUCTORY DISCUSSIONS

Like icebreakers, these discussions are intended to help participants address a specific aspect of the topic while getting them engaged in group process.

### SELF-TESTS

These tests help to make the training more individualized and enable trainees to understand their own traits and tendencies regarding the subject matter.

### WORKSHEETS

After participants write their responses to the questions on these forms, the facilitator leads a group discussion about their responses. The purpose is to help learners focus on the concepts being taught.

### CASE STUDIES

Some case studies are more detailed than others, but all are brief enough to process in relatively short spans of time. After participants have read the cases, ask them to analyze them and make recommendations either in small-group or all-group discussions. If you decide to break into small groups, ask a representative from each to report their findings to the group as a whole. If you'd prefer, you can convert the case studies into role plays by assigning participants to act as each of the characters.

### ROLE-PLAY EXERCISES

These exercises are designed for groups of two, three, four, or five, as each role play requires. If there are extra persons, assign them to double in a role with another character or ask them to serve as observers.

Some role-play exercises have a separate page of "General Instructions" (to distribute to everyone), followed by separate "Confidential Instructions" (to distribute to persons playing each role). Other role-play exercises use character roles only and do not have separate General Instructions. For ease of distribution, make copies of each character role on a different color paper.

After instructions are distributed, instruct participants to act out the scene from their

character's viewpoint. Tell participants they may change their behaviors or positions only if the points raised by other characters would cause them to do so in a real-life situation. If more details are needed in some of the shorter role-play exercises, advise participants that they can embellish the "facts" of the cases as long as their points are consistent with their assigned roles.

### PRACTICE EXERCISES

These are brief exercises that allow participants to refine their skills by immediately applying new strategies.

### DEBRIEFING

An essential part of the training, this is a facilitated discussion following each activity in which participants dissect the training activity and analyze the quality of their responses. It is also a perfect time for you to drive home the key teaching points. Discussion questions are provided to help you facilitate this portion of the session.

> Note: While some names of characters in the case studies and role-play exercises have been modeled after well-known persons or fictitious characters, this has been done for the amusement of readers (and the author), and any resemblance to real persons, living or dead, is entirely coincidental. The case studies and role plays are either fictitious or are composites of numerous situations.

# Effective listening

## Training Tool #1

**Two-party warm-up exercise on the use of questioning and reflective skills**

# Practice in effective listening

**TYPE:** Icebreaker

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to understand the importance of questioning and reflective skills in all types of interactions;
- to identify strengths and needed improvements in listening skills.

**MATERIALS NEEDED:** A copy of the list of topics on page 5 for all participants

**PROCEDURE:**

After a 10- to 15-minute overview of questioning techniques and reflective skills, ask participants to select a partner. Distribute the list of topics and note that the person who is tallest of the two will be the speaker and the other will be the listener. The speaker should select one of the topics to discuss with the listener. The objective will be for the listener to practice his/her questioning and reflective skills throughout the discussion on that topic. Then give these tips:

- **Tips for speakers:** Finish the sentence; then explain. Use clear, vivid language to help the listener understand your meaning. Act as you would in a normal conversation. Give each response in only a sentence or two so that the listener can use various techniques to draw more information out of you.
- **Tips for listeners:** Keep the focus on the speaker and use questions or reflective listening techniques (e.g. paraphrasing, reflecting feelings, reflecting meanings, or summarizing) to obtain more information. As you use these techniques, try to maintain the flow of a normal conversation.

Discussions between speaker and listener should take no more than five minutes for each selected topic. Alternate the speaker-listener roles after each topic is addressed.

**DEBRIEFING:**

1. How would you evaluate the listen-talk ratio of your dyad? Did the listener allow the speaker enough time to respond?
2. What was the effect of the listener interjecting questions or reflective comments in the conversation?
3. Did the listener use appropriate questions or reflective skills at the right times?
4. When questions were asked, did the best results come from open-ended or close-ended questions? Please explain your response.
5. How skillfully did the listener use reflective techniques?
6. Did the listener interrupt the speaker? If so, what was the effect?
7. Could anything that the listener did be interpreted as a "door closer," (i.e. words or phrases that cut off the flow of information)?
8. Did the listener disagree with any points made by the speaker? If so, did the focus of the conversation shift to the listener rather than the speaker?
9. What did your partner do well in these exercises? What improvements would you suggest?
10. What did you learn about yourself during this exercise? About your partner?

## Training Tool #1

### PRACTICE IN EFFECTIVE LISTENING

TOPICS

- The best advice I ever had about communicating in professional situations is to . . .
- If I could improve one thing about the way I communicate with others, it would be to . . .
- My most embarrassing gaffe in communication was when I . . .
- In regard to the way people communicate, my pet peeve is people who . . .
- When I think of some of the best communicators I know, the quality they seem to have in common is . . .
- If there's one thing I've learned about communicating with patients, it's . . .
- It's a lot easier to establish a collaborative relationship with my associates or community partners when . . .
- The best way to build trust in a relationship is to . . .
- If you observed my nonverbal communication during a conversation, you'd mainly see me . . .
- My nonverbal cues are most revealing to the other party when I . . .
- I have the most trouble reading the nonverbal behavior of people who . . .
- I'm a particularly good listener when . . .
- Compared to professional communications, in social situations I'm usually more . . .

**Nonverbal behaviors that demonstrate active listening to the speaker**

## Training Tool #2

# The look of listening

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Effective listening

**OBJECTIVE:**

➥ to identify which nonverbal behaviors demonstrate active listening to the other party and which behaviors have the opposite effect.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Ask the group to physically demonstrate through their nonverbal behavior that they are interested in what you have to say. Continue speaking for a minute while the group adjusts their behaviors to show how they demonstrate interest. Then ask: "What nonverbal behaviors did you use to show that you were actively listening and interested in my comments?" Draw two columns on the flip chart and list answers in the first column. Likely responses are: alertness, leaning forward, direct eye contact, nodding, open body language (i.e. not crossing arms or legs), and taking notes.

Next, ask the group to do the opposite: to show you through their nonverbal behavior that they are *disinterested* in what you are saying. Write these responses in the second column. Typical responses are: minimal or no eye contact, closed body positions (e.g. crossed arms or legs), yawning or sleeping, doing something else, fidgeting, checking the time, and turning away from the speaker.

**DEBRIEFING:**

1 What is the importance of the nonverbal aspect of listening? What messages do positive nonverbal messages send to the speaker?
2 When do nonverbal behaviors that indicate active listening come to you most naturally?
3 What circumstances, if any, would require you to act interested in what the speaker is saying even when you are not?
4 What is the relationship between active listening and your ability to get the speaker to divulge additional information?

## Training Tool #3

**Identifying the obstacles and tendencies that contribute to faulty listening**

# Intro to listening

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to identify factors that cause or contribute to faulty listening;
- to understand the importance of listening skills in health care careers.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Ask participants whichever of the following questions would best introduce your session on listening skills:

1 What is the difference between hearing and listening?

Hearing is one of the five senses; it involves sound waves striking the eardrum and causing vibrations that are sent to the brain. Listening is an art, involving receiving, perceiving, assignment of meaning, and responses to the message.

2 When you don't listen well, what are some of the causes?

Possible answers include: fatigue, being preoccupied, hearing problems, trying to hear people who speak inaudibly, and being distracted by noises or commotion.

Also point out that people find it difficult to listen due to message overload, compounded by the fact that people spend 40–60% of their waking hours listening. Rapid thought is another cause of poor listening: humans can understand up to 300 words per minute, but the average person speaks at 100–40 words per minute. The mental spare time can contribute to a wandering mind.

3 What are examples of poor listening by health professionals during patient visits?

Examples could include: tuning out information that does not fit with a suspected diagnosis (insulated listening); not picking up on clues about hidden needs that should lead to additional questioning (insensitive listening); and distractions, such as trying to figure out how to enter data on the electronic medical record while the patient is still speaking, or trying to figure out what to ask next, instead of fully listening to patients' responses.

**DEBRIEFING:** Summarize key points at the end of this discussion.

**An adult version of the old "telephone game" from elementary school**

## Training Tool #4

# Person-to-person

**TYPE:** Demonstration

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to demonstrate the extent to which messages become distorted when passing through multiple channels;
- to illustrate the primacy-recency effect;
- to show how understanding is impaired by the inability to ask questions.

**MATERIALS NEEDED:** Copies of a worksheet selected from the following pages for all participants. Your choices are "A Regrettable Celebration" (about fireworks injuries) and "Thrills and Chills" (about amusement park injuries). Whichever scenario you choose, only distribute the worksheet to those watching the demonstration. Don't give copies to volunteers until the exercise has been completed.

**PROCEDURE:**

Ask for six volunteers, and assign one as door monitor. Of the five persons remaining, ask one to stay in the room and the others to go into the hall and wait nearby until they are called by the door monitor one at a time.

Distribute copies of the selected worksheet to all participants observing this exercise – but not to the volunteers. Tell participants that this exercise will be a re-creation of a childhood game in which a message is whispered from one person to another to see how accurately the final version comes through. In this exercise, however, the messages will not be whispered but will be delivered orally from one volunteer to another. Also note that each volunteer will repeat the story to his/her successor, but that no questions are allowed.

Ask participants to jot down their impressions on the worksheet. Then read the selected story to Volunteer #1. After the first volunteer has heard the story, ask the door monitor to bring in Volunteer #2. Tell Volunteer #1 to repeat the story to Volunteer #2, adding that no questions are allowed. Continue to bring in a new volunteer until all five have heard the story. Ask the last volunteer to repeat the story to participants (i.e. the observers).

At the conclusion of the exercise, distribute copies of the selected worksheet to the volunteers so that they can see how the story changed from beginning to end.

**DEBRIEFING:**

Ask participants to review their worksheets as they respond to the following questions:

1 To what extent did the message stay intact from the first volunteer to the last? Given that most of you have done this exercise in childhood, why are we not that much better at it as adults?
2 What additions, deletions, and other distortions did you notice as the message traveled from one person to the next?
3 What do you see as the causes of these changes and distortions? Did the volunteers' inability to ask questions play a role? If so, how?
4 Which messages were most accurately transmitted throughout the exercise? (Point out that people have a tendency to recall information that was delivered at the beginning and ending of the message, while losing points in the middle. This is known as the "primacy-recency" effect.)
5 How was accuracy affected by a story with so many statistics and minute details?
6 What does this exercise teach us about listening? What is the lesson about the accuracy of messages that pass through multiple channels? How can these lessons be applied to health care settings?

## Person-to-Person

REGRETTABLE CELEBRATION

Backyard fireworks have only been banned in five states in the USA due to safety concerns – New Jersey, New York, Delaware, Massachusetts, and Rhode Island – despite the fact that injuries from fireworks at home are increasing nationwide. One such injury occurred in Independence, Oregon, when 12-year-old Carrie Cranshaw was celebrating a national holiday with her family, including her father, mother, twin sisters, and a brother. Following a backyard picnic, Carrie was lighting 14 sparklers for the younger children when the first one ignited the others all at once. Carrie looked down and saw that her hand was on fire. She received third-degree burns and spent 12 days in the hospital and 72 days in outpatient therapy. The thumb and index finger on her right hand were partially amputated, and she has permanent scarring on her left hand. One of her twin sisters, Mandy, who reached out to receive a sparkler, received a five-inch laceration on her hand and forearm that exposed muscle, thus requiring plastic surgery. Their brother, Andrew, had debris lodged into his right hand and arm. Sister Candy was several feet away and was not injured. The family had received the fireworks by mail order.

| Volunteer | Additions | Deletions | Distortions |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

## Person-to-Person

THRILLS AND CHILLS

A seven-year-old boy suffered major injuries when riding the Terror Train at the Loosey Goosey theme park near Duluth, Georgia. The ride is a spinning roller coaster with speeds of up to 60 miles an hour. The boy and his mother arrived late at the ride and buckled themselves in quickly. As the attendant whizzed by each car to inspect the riders, he told the mother and son to tighten their belts, and rushed back to the operating booth to start the ride. Because their seatbelts were not secured properly, the boy and mother fell out of their car as the coaster was climbing toward the top of the first hill. The mother landed hard into a lake below and was rescued by two park employees. Miraculously, she only suffered a concussion, cuts, and bruises. The boy hit his head on the boat dock before falling into the water. He sustained traumatic brain injury (TBI) and broke his right leg in four places. The boy is still hospitalized after four surgeries and is expected to survive, but his mother worries about possible outcomes from TBI, such as cognitive deficits, motor disabilities, and emotional or social dysfunction. The attendant later testified that he did not remember if he watched the mother and son tighten their seatbelts. Nor was he aware that they only spoke Spanish.

| Volunteer | Additions | Deletions | Distortions |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

**Applying questioning techniques to a patient care visit**

## Training Tool #5

# 20 questions

**TYPE:** Practice exercises

**ESTIMATED TRAINING TIME:** 60 minutes

**THEMES:** Effective listening, improving patient relationships, customer service

**OBJECTIVES:**

- to identify various types of questioning techniques;
- to apply the techniques skillfully in patient care visits.

**MATERIALS NEEDED:** A copy of the "Practice Exercises" for all participants

**PROCEDURE:**

In a brief lecture, explain the various nondirective (patient-centered) listening skills that are used to bring out more information from patients.

- **Open-ended questions:** Questions that give you a paragraph response rather than a simple "yes" or "no," normally starting with the words: how, what, when, where, tell me about, or explain to me.
- **Reflective questions:** Questions or statements in which you reflect the speaker's feelings ("You said you feel lonely at times, right?") or meanings ("You are concerned that your daughter won't see a doctor.")
- **Paraphrasing:** Restating what the speaker said in your own words: "What I hear you saying is that you are having a hard time juggling being a caregiver to your ailing husband and caring for your children."
- **Empathizing:** Listening with your heart – not only to know what the person is saying, but to understand and "feel" it. For example, "It sounds like this is a very painful time for you and your family."
- **Silence:** Looking attentively at the speaker without commenting, in order to give the speaker time to process thoughts and divulge more information.

While these facilitative listening techniques are used to draw more information from patients at the beginning of the visit, also point out that directive listening skills – close-ended questions, summarizing, advising, educating, referring, etc. – tend to be most effective when used toward the end of the visit. Note that nondirective questions are normally more difficult to master and therefore require more practice.

To give participants practice in using nondirective listening techniques, ask them to get a partner and distribute copies of the practice exercises. Assign each group a different set of four questions each and tell them to take turns practicing their responses during the next 20 minutes.

Give the following instructions for completing the exercise.

- When you respond to the situation described in the first column, feel free to invent additional details as you see fit.
- Suggested listening techniques appear in the second column. You may respond by using one or both suggested techniques.
- If you choose to use a technique other than those suggested, tell the speaker what other type of questioning you are using and why you feel that would be more appropriate.
- When playing the patient's role, be sure to evaluate how well the questioner used the techniques and offer suggestions for improvement.

**DEBRIEFING:**

So that the entire group can benefit from all 20 questions, ask each dyad to report on the four questions they addressed.

1. Which questioning techniques seemed most difficult to master? Please explain.
2. Did you find it difficult to ask questions when you had an urge to give advice instead? If so, how did you resist that urge?
3. What is the advantage of using these techniques to draw out more information even when you believe you already have the answer?
4. To what extent did your paralanguage (tone, volume, pitch, vocal variety, speaking rate, etc.) affect your messages?
5. Why are these techniques effective in helping people to open up? What are the other benefits of these listening techniques – particularly to the provider-patient relationship?
6. Why do you think communication experts consider techniques such as paraphrasing and reflective listening to be confirming behaviors?
7. Given that these terms are closely related, what do you see as the difference between paraphrasing and reflecting meaning?
8. When is it most effective to use silence in a patient interview? What nonverbal behaviors should you use with silence?
9. What do you see as a reasonable listen-talk ratio at the beginning of the patient visit compared to the end?
10. What did these practice exercises teach you about your own strengths? What did they teach you about areas in which improvements are needed?

## Practice Exercises

20 QUESTIONS

Practice Exercises: Situation Questions

| | |
|---|---|
| 1 As you enter the exam room, you see that your 46-year-old female patient is crying. | Open-ended:<br><br>Empathy: |
| 2 Mr. Carlin tells you that he thinks he is losing his mind. | Open-ended:<br><br>Reflecting feeling: |
| 3 A patient tells you a long personal story about her marital problems, and you aren't sure where the story is going. | Reflecting meaning:<br><br>Open-ended: |
| 4 An 82-year-old woman patient complains of shortness of breath and a pain in her back between her shoulder blades. | Open-ended:<br><br>Paraphrasing: |
| 5 Mr. M. Fattick says that he doesn't think you realize how much pain he has been enduring. | Reflecting feeling:<br><br>Empathic: |
| 6 A 57-year-old woman tells you that she has nearly all the symptoms of a disease she saw described on a medical reality TV show. | Paraphrasing:<br><br>Reflecting meaning: |
| 7 A 22-year-old who complains of being stressed by his enormous student debts asks you to prescribe a specific, very powerful muscle relaxant. | Open-ended:<br><br>Reflecting feeling: |
| 8 An unusually attractive 31-year-old female asks for a referral to a plastic surgeon for a rhinoplasty, chin implant, and eyebrow lift. | Open-ended:<br><br>Reflecting meaning: |

| | | |
|---|---|---|
| 9 | A teenage male sheepishly asks to be tested for AIDS. | Open-ended:<br><br>Reflecting feeling: |
| 10 | A young single mother brings in her toddler son for immunizations and you notice a large hand-shaped bruise on his buttocks. | Opened-ended:<br><br>Reflecting feeling: |
| 11 | A patient with COPD says that you are wasting your breath trying to get her to quit smoking because that would be impossible for her. | Paraphrasing:<br><br>Reflecting meaning: |
| 12 | A 27-year-old woman whose fiancé recently left her at the altar complains of severe intermittent pains in her right side. | Reflecting feeling:<br><br>Open-ended: |
| 13 | A patient confesses having feelings for you – extending "far beyond" the provider-patient relationship. | Reflecting feeling:<br><br>Open-ended: |
| 14 | After being your patient for more than 10 years, Jess Wunderin is all of a sudden asking you dozens of questions about your training and qualifications. | Open-ended:<br><br>Reflecting meaning: |
| 15 | A 48-year-old executive tells you that he cannot point to a specific problem, but that he feels "off-kilter" and knows that something is terribly wrong. | Open-ended:<br><br>Reflecting meaning: |
| 16 | A long-term patient is extremely upset that your practice will no longer accept her health insurance. | Paraphrasing:<br><br>Reflecting feeling: |
| 17 | A 52-year-old male patient hints at impotence and seems clearly uncomfortable discussing the subject. | Reflecting feeling:<br><br>Open-ended: |

| | | |
|---|---|---|
| 18 | A patient says he drinks a bottle of red wine each day, but he's doing it "for health reasons." | Paraphrasing:<br><br>Reflecting meaning: |
| 19 | A nervous 16-year-old high school student's voice cracks as she tells you she has missed three periods. | Reflecting feeling:<br><br>Reflecting meaning: |
| 20 | A 13-year-old complains about stress from problems at school and you notice a significant worsening of her acne. | Reflecting feeling:<br><br>Open-ended: |

## Training Tool #6

**Identifying the various ways health care professionals "hear" their customers**

# Organizational listening

**TYPE:** Worksheet

**ESTIMATED TRAINING TIME:** 45 minutes

**THEME:** Effective listening, communicating with your community

**OBJECTIVES:**

- to understand the numerous options for "hearing" patients and others;
- to show that organizational listening involves structural as well as behavioral methods.

**MATERIALS NEEDED:** A copy of the worksheet on "Organizational Listening" for all participants

**PROCEDURE:**

Point out that organizational listening involves the way your health care organization listens to patients, employees, colleagues, vendors, community members, and others. Also note that there are many ways this listening can be improved, especially given today's technologies.

After forming small groups of four to five persons each, assign each small group to address three or four questions on the worksheet on "Organizational Listening." (So that all of the questions are covered, assign questions 1–4 to the first group, 5–9 to the second group, and so on.) In the first column, they should write what your health care organization currently does to listen in each circumstance or what most likely would be done if these situations occurred. In the second column, they should identify what other measures could be employed to improve the organization's ability to listen. Encourage participants to think out-of-the-box as they develop recommendations for the second column.

**DEBRIEFING:**

1 Does it seem that our organization is more comfortable with one-to-one communication and less comfortable with "organizational listening"? If so, what are some possible reasons why?
2 What is the importance of obtaining information and feedback from the persons we work with and those we serve on a proactive basis?
3 Based on the responses in the first column of the worksheet, how well are we currently listening – both internally and externally?

4 What types of channels did your group suggest for various types of organizational listening? (Possible answers include: asking friends or family members to serve as "listening posts" in the reception area; managing by walking around, i.e. MBWA; guest satisfaction surveys; conducting focus groups; making notes or keeping tallies of suggestions or complaints; asking scripted questions at the beginning or end of visits; having face-to-face meetings; listening to the grapevine; exchanging emails; suggestion boxes; comment cards; and ensuring that performance appraisals are "two-way" interactions so that you receive information as well as provide feedback; etc.)
5 Do you believe that listening to the grapevine is an effective form of organizational listening? Why or why not? Is there a difference between the grapevine and gossip? What precautions should you take to ensure that such messages are accurate?
6 Which, if any, of the suggested improvements in the second column would help the organization listen to customers, colleagues, and the community more effectively? Are the suggestions practical? Are they affordable?
7 If you decided to offer incentives to increase response rates to your inquiries, what types of incentives could you offer? How would the incentives vary for different types of groups?

## Organizational Listening

| Situation | What We Now Do: | What More We Can Do: |
|---|---|---|
| 1 You aren't quite sure why many more patients than usual either have been missing or canceling their appointments during the last few months. | | |
| 2 You would like to gauge how physicians and staff members feel about the quality and content of weekly all-group meetings. | | |
| 3 You are considering providing more outreach services to uninsured and underinsured patients in the community, and would like to focus on the types of services that target populations most need and value. | | |
| 4 You wonder if your health center is getting the best possible prices on office and medical supplies. | | |
| 5 Staff members in the billing office seem to have extremely low morale – but won't tell their supervisor or other practice leaders why. | | |
| 6 You'd like to learn about patients' and visitors' first impressions so that you can make any necessary improvements in the reception area and/or front office. | | |
| 7 You are concerned about how patients may react if you discontinue your practice's relationship with a certain managed care organization. | | |

| Situation | What We Now Do: | What More We Can Do: |
|---|---|---|
| 8 You'd like to establish a better relationship with your hospital's administration and reduce current tensions. | | |
| 9 You don't understand why your practice does not receive referral reports from other specialists in a nearby medical practice on a timely basis. | | |
| 10 It has come to your attention that a growing number of patients have complaints about your practice but are reluctant to report them. | | |
| 11 You're about to give a presentation to a local service organization, and would like to find out in advance what they'd most like to learn. | | |
| 12 You'd like to learn more about what new employees think about the organization and their jobs, but you don't have time to visit with each of them individually. | | |
| 13 Staff members in your office feel that they have many great ideas – but not enough opportunities to provide input. | | |
| 14 You'd like to transmit more information to patients on an ongoing basis – and receive input from them as well. | | |
| 15 You are about to plan a major renovation of your practice and want to ensure that it is as "patient-friendly" as possible. | | |

## Training Tool #7

# Listening between the lines

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to explore the differences between "active" and "empathic" listening;
- to identify ways to demonstrate empathic listening to others.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Ask participants to define active listening and list their responses on the flip chart. Then point out that active listening involves the following.

- "Attending" skills – demonstrating that you're listening by positioning yourself at eye level with the speaker, leaning forward, giving direct and warm eye contact, and avoiding blocking behaviors, such as crossed arms or legs.
- "Following" skills – nodding, asking an occasional brief question ("Really? What happened next?") or inserting a brief comment or sound ("Hmmm. That must have been painful") to show the speaker that you're following the message.
- "Reflective" skills – reflecting the speaker's meaning, either by paraphrasing your understanding of their feelings ("You felt hurt when he said that") or their meaning ("You would have preferred a more direct response from her"). Note that reflective responses have two purposes: they help to ensure accuracy because the speaker can correct you if you've misunderstood, and they often result in the speaker expounding on their comments to further explain – thus giving you more information.

Next, ask participants, "What is the difference between active and empathic listening?" While some are likely to respond that the terms are synonymous, point out that empathy requires a deeper level of listening that involves attention to the emotional subtext of the speaker's comments. As commonly described, this form of listening involves "listening between the lines" or "listening with the heart."

**DEBRIEFING:**

1 What are some general guidelines for being a better empathic listener? (Try to avoid being judgmental; consider the speaker's verbal and nonverbal behaviors to tune in to feelings as well as thoughts; to the extent possible, try to put yourself in the speaker's position; and demonstrate compassion and understanding in your nonverbal responses – particularly with your eyes and other facial expressions.)

2 As you listen with empathy, what are examples of responses to avoid? (Don't say: "I know exactly how you feel," as no one can ever know exactly how another feels. Instead, you might say, "I've had a similar experience." Another taboo: "You shouldn't be upset about that." Everyone has the right to feel the way they feel. Accept their feelings as legitimate. Talk people through their emotions – not out of them.)

3 What are some examples of occasions when you should use empathic listening with patients, colleagues, or others? (A patient is describing a recent death in the family; a colleague is upset because she lost her mother's ring; a coworker is excited because she became engaged the night before. Point out that empathic listening involves tuning in to all types of emotion: sadness as well as happiness, and the myriad emotions in-between.)

4 Under what circumstances would you listen actively rather than empathically? (Examples include: taking histories that do not involve emotional components; hearing factual reports – whenever the emotional subtext does not outweigh the factual content.)

5 Is there such a thing as being *too* empathic? Should there be at least some emotional detachment in order to avoid becoming too emotionally invested or involved in the speaker's feelings and tribulations? Please explain.

6 What are the advantages of empathic listening in health care settings? How does empathic listening affect the quality of your professional and personal relationships?

## Training Tool #8



# Self-test: are YOU a good listener?

**TYPE:** Self-test

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to identify participants' strengths and weaknesses as effective listeners;
- to relate the principles of effective listening to each individual learner.

**MATERIALS NEEDED:** A copy of the self-test on the following pages: the self-test (distribute this first); and the score sheet (distribute this after participants have taken the test)

**PROCEDURE:**

Distribute a copy of the self-test to each participant and give them approximately 15 minutes to fill it out. Because people tend to behave somewhat differently at home than at work, tell participants that they should consider their listening tendencies in terms of work (i.e. how they relate to colleagues and patients). Also advise them to select the answer for each question that best describes their actual tendencies rather than the answer they think is "correct."

**DEBRIEFING:**

After participants have completed the self-test, distribute the score sheet and ask them to read the explanations for their responses. Note that they can determine their total scores by seeing how many marks they have in each category. Ask for a show of hands on how many persons have at least 15 marks in the "Great!" category, and point out that this demonstrates superior skills, but does not mean that additional skill development is not necessary. After all, we all have room to improve.

Then ask the following questions:

1 Did any of the "correct" answers surprise you? Why or why not?
2 Do you think that the results of this test were accurate in describing your listening skills? Why or why not?
3 For answers in the "Work on this" or "Work harder" categories, what will you do specifically to improve your skills?

## Listening Self-test

ARE *YOU* A GOOD LISTENER?

**Please select the response for each question that most closely describes your listening tendencies.**

(Note: Be sure to select the response that is most true about your tendencies, not the one you think you're "supposed" to choose.)

____ **1 Associates and friends would describe my listening skills as:**
- a One of my best qualities
- b One of my key problem areas
- c They rarely if ever mention my listening skills

____ **2 When I don't entirely grasp the speaker's meaning:**
- a I let the speaker continue, and assume I'll pick up their meaning from other comments
- b I usually ask clarifying questions
- c I ask questions if I consider the comment important

____ **3 When I'm trying to ensure that I've understood the speaker's comments, I use the restatement technique (paraphrasing):**
- a Regularly
- b Infrequently
- c Hardly at all

____ **4 When a speaker is finding it difficult to make a point:**
- a I am attentively silent while allowing enough time for the speaker to finish his/her thoughts
- b I suggest words or finish their sentences to help them complete their thoughts
- c I show my impatience through my nonverbal behavior

____ **5 In regard to my eye contact, I tend to:**
- a Look directly at the person who is speaking
- b Look down or away, so that we'll both feel more comfortable
- c Intermittently look up from what I am doing to show that I am listening

____ **6** **When someone is saying something I disagree with, I tend to:**

a Tune them out
b Listen just as attentively as I would with those I agree with
c Mentally rehearse how I will counter their comment

____ **7** **When a speaker is droning on and on to the point of being repetitious:**

a I gently interrupt with a comment or question that will lead them into a new direction
b I don't interrupt – no matter how long it takes the speaker to finish his/her thoughts
c I ask, "Does your train of thought have a caboose?"

____ **8** **When a speaker is telling me something with an emotional subtext:**

a I ask questions or make comments that allow the speaker to get back to the facts
b I continue to listen while trying to keep an emotional distance
c I am able to shift easily from active to empathic listening

____ **9** **When people talk about things that do not interest me:**

a I tune them out
b I look for ways to cut the conversation short or change the subject
c I try to explore their comments to find out why the subject is interesting to them

____ **10** **My colleagues would say that during most of our conversations:**

a I am doing most of the talking
b I am mainly listening
c We each have a good ratio of talking and listening

____ **11** **When people express something revealing about themselves:**

a I feel free to relate to their comments while continuing to ask about their experiences
b I tune in completely to the speaker, keeping the focus on them
c I usually turn the conversation back to myself

____ **12** **When people press my "hot buttons":**

a I find it difficult to continue listening
b I let them know immediately what comment was offensive
c I ask questions to check their intentions and see if I interpreted their statement correctly

____ **13** **When people say things I expect – or that I've heard a hundred times before:**

a I change the subject because I know what they'll say
b I keep listening anyway since they may say something new or unexpected
c I save time by telling them what I am assuming they are about to say and see if that's correct

____ **14** **When people describe a negative feeling that seems directed at me:**

a I ask clarifying questions to learn more about the speaker's concerns with an eye toward problem-solving
b I take their comment with a grain of salt
c I tend to take the comment personally and get defensive

____ **15** **I consider myself to be:**

a A critical listener, focusing on erroneous statements or inconsistencies that I can retort
b A nonjudgmental listener who does not evaluate comments while listening
c An occasionally judgmental listener, who tries hard to conceal judgments while the speaker is revealing information

____ **16** **I think that meetings to seek people's input are:**

a A waste of time, particularly when such meetings interfere with our work
b A valuable use of time, regardless of how much work we have to do
c Both a curse and an opportunity, depending on who is leading the meeting

____ **17** **When people continue asking questions or repeat the directions or instructions I have just given to them:**

a I am pleased that they want to ensure that they have understood my message
b I get impatient, feeling that they didn't listen to my instructions closely enough
c I assume they are questioning my judgment

____ **18** **When people are speaking to me and I get a text message or cell phone call:**

a I tell them to keep speaking because I excel at multi-tasking and can listen while doing other things

b I first check to see if there's an emergency and if not, continue listening to the person who is with me

c I ask the person to wait a minute while I take the call or reply to the message

____ **19** **When a speaker says something I need to remember:**

a I normally jot down notes

b I trust that I will remember the comment and write it down later

c I ask the speaker to remind me of the comment later

____ **20** **During conversations, when there are noises or other distractions:**

a I often find it difficult to get my mind back on the conversation

b I make note of the distraction and if nothing is urgent, get back to the conversation

c I'm so "into" the conversation that I don't notice the noise or distraction

## Effective Listening Skills

LISTENING SELF-TEST
Score Sheet with Explanations

| | Great! | Work on this | Work harder |
|---|---|---|---|
| 1 | **a**<br>People are noticing and appreciating your listening skills! | **c**<br>If people aren't complimenting your skills, why not? | **b**<br>Take heed of what your colleagues and friends are telling you. |
| 2 | **b**<br>When you don't know, ask! | **c**<br>At least you're asking sometimes – but how do you know if it's important if you don't know what they're saying? | **a**<br>You're depending on guesswork – for the sake of accuracy, it's better to ask. |
| 3 | **b**<br>It's best to paraphrase only when you need to confirm your understanding, check for accuracy, and get more information. | **a**<br>If you paraphrase ALL the time, you'll drive everyone crazy. | **c**<br>You're not using a vital listening skill. Practice using it! |
| 4 | **a**<br>You recognize that some people process their thoughts more slowly than others – and strive to learn from their words, not yours. | **b**<br>It's fine to help people along when they're really struggling, but be careful that you don't over-assume that you know their points. | **c**<br>This is a non-confirming behavior – stop doing this! |
| 5 | **a**<br>Direct and warm eye contact is one of the best ways to invite more conversation while confirming the speaker! | **c**<br>At least you're looking at the speaker now and then, but why can't you give your full and undivided attention? | **b**<br>Your behavior is most likely pushing people away – and you're also missing vital nonverbal cues! |

| | Great! | Work on this | Work harder |
|---|---|---|---|
| 6 | **b**<br>You realize there's a lot to learn from those with different viewpoints, and we're not all made from the same cookie cutter! | **c**<br>At least you're listening for some purpose, albeit not the right one! Your reliance on critical thinking may impede quality communication. | **a**<br>Are you just talking to find people who agree with you? What a loss! |
| 7 | **a**<br>When people have a serious case of verbal vomit and don't know when to stop talking, it's appropriate to gently step in. | **b**<br>A good quality, but will you ever complete this conversation? | **c**<br>Funny, but rude. |
| 8 | **c**<br>Knowing how and when to shift gears to a deeper level of listening is essential for us all – especially in health care. | **a**<br>While you may not want some conversations to be more emotional than factual, don't forget that emotions expressed are a key part of the "facts" you are seeing. | **b**<br>You may come across to others as cold and unsympathetic. |
| 9 | **c**<br>Not only are you likely to learn more about the speaker, you're also likely to hear something that *does* interest you. What an unselfish, other-oriented listener you are! | **b**<br>Sometimes this is necessary so that you're not bored into unconsciousness, but you could be missing a great opportunity to collect more insights about the speaker. | **a**<br>This places a great burden on the speaker – having to "entertain" you to capture your attention. |
| 10 | **c**<br>Conversations don't always need to be a 50/50 ratio of talking and listening, but good relationships tend to even out somewhere near this range over time. | **b**<br>Excellent! But in the interest of being a great listener, you may not be sharing enough of your own perspectives to be a good conversation partner. | **a**<br>This could be due to the type of job responsibilities you have . . . or you could be a motor-mouth. |

| | Great! | Work on this | Work harder |
|---|---|---|---|
| 11 | **b**<br>Because the speaker is revealing something, you realize that's a time to keep the focus on the speaker rather than interject your own thoughts and experiences. | **a**<br>This is certainly preferable to shifting the conversation entirely back to your court. | **c**<br>Is the world all about you? |
| 12 | **c**<br>You realize there's a chance that you've misinterpreted the speaker's meaning. If you didn't, you can tell the speaker what's bugging you. | **b**<br>Better to clarify the matter before you miss other parts of the speaker's message, but be gently assertive. | **a**<br>A very human response, but it doesn't contribute to mutual understanding. |
| 13 | **b**<br>Good instinct! You may think you've heard everything and know where the conversation is headed – but then again, you may be surprised. | **c**<br>It sometimes helps to do this when the speaker's comments have been heard before, but are you sure you know what he/she is leading to? | **a**<br>Are you available for psychic readings? |
| 14 | **a**<br>Sometimes the most helpful information is the most difficult to hear. Continue resisting your urge to defend yourself, at least until you've learned what you need to know. | **b**<br>You're not taking the comment personally, and at least you're listening. But listen for any truths in the speaker's comments and try to take them seriously. | **c**<br>A very human reaction, but not one of the hallmarks of an effective listener. |
| 15 | **c**<br>Being human, it's hard to completely avoid making judgments, but try to appear nonjudgmental and keep an open mind. | **b**<br>Are you sure you are this open-minded? If you really are, that's amazing, and you can change this score to the "Great" category instead. | **a**<br>Listening for things to rebut can be exhausting – not to mention annoying. |

| | Great! | Work on this | Work harder |
|---|---|---|---|
| 16 | **b**<br>Such meetings are great opportunities to share ideas, reach better group decisions, build relationships and create an atmosphere of inclusiveness. | **c**<br>A great facilitator is a major plus, but any participant can speak up and make a difference. | **a**<br>Remember that relating to and listening to others is just as much a part of your work as your usual tasks. |
| 17 | **a**<br>Your message may not have been entirely clear, so it's better to verify and be safe than sorry. | **b**<br>Rather than be impatient with your coworker, be thankful you are working with someone who wants to do things right. | **c**<br>Are you perhaps a little too sensitive? |
| 18 | **b**<br>Looking away momentarily to check for emergencies is certainly understandable for health care professionals. Otherwise, you wouldn't have your phone or Blackberry turned on! | **c**<br>This is the most polite and confirming response, but shouldn't you check for emergencies? | **a**<br>This tells the speaker that he/she is not as important as your incoming calls or messages. |
| 19 | **a**<br>Effective listeners are never far away from pen and paper – or a computer. | **b**<br>You may have an outstanding memory, but with all the commotion in health care settings, can you be sure? | **c**<br>As the listener, it's your responsibility to recall what is said; don't shift this responsibility to the speaker. |
| 20 | **b**<br>Good! Even when listening, it's important to be alert to your environment and then get back to the matter at hand. | **c**<br>This shows that you are extremely "present" in the conversation, but what if there's a fire? | **a**<br>Practice on regaining your focus! |

**Dissecting situations to identify the various types of faulty listening**

## Training Tool #9

# Faulty listening habits

**TYPE:** Mini-case studies

**ESTIMATED TRAINING TIME:** 45 minutes

**THEME:** Effective listening

**OBJECTIVES:**

- to identify various types of bad listening habits;
- to understand the nuances of faulty listening;
- to demonstrate that both the speaker and listener bear responsibility for effective communication.

**MATERIALS NEEDED:** A copy of the "Faulty Listening Habits" case study sheet for all participants

**PROCEDURE:**

Give a brief lecture on the various types of faulty listening habits:

- pseudo-listening: pretending to listen;
- selective listening: listening only to things that interest you or grab your attention;
- insulated listening: tuning out things you don't want to hear;
- defensive listening: interpreting innocent comments as personal attacks;
- insensitive listening: listening only at a surface level and not grasping hidden meanings;
- stage hogging: tuning out the speaker to plan what you'll say next and draw the conversation back to yourself;
- ambush listening: listening mainly for information that can be used to disagree with or correct the other party.

Next, distribute the case study sheet to participants. Ask them to spend 15–20 minutes working in small groups to identify the types of faulty listening habits in each situation. Note that this will be followed by an all-group discussion.

**DEBRIEFING:**

1 What faulty listening habits are possible for each case? Did some cases involve more than one faulty listening habit?

Correct answers are subjective, but consider these possibilities:

a Case #1 – A, B, C, and E
b Case #2 – C and E
c Case #3 – B and D
d Case #4 – A, C, and E
e Case #5 – All

2 What were the solutions suggested for each faulty listening habit you identified?
3 What do these cases teach us about the responsibilities of both speaker and listener, regardless of who is most right or most wrong?

Explain that this exercise was not only to identify the types of faulty listening habits; it was also to show that both parties – speaker and listener – bear responsibilities for effective communication.

4 How important is timing when we wish others to listen to us?
5 How important is the listener's mood (i.e. frame of mind)?
6 To what extent is our memory of a conversation a barometer of how well we listened?
7 What can be done in health care settings to maintain effective inter-professional communication – even when things are quite hectic?

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Thanks to Karen Mitchell, MD, Director of the Providence Family Medicine Residency in Southfield, Michigan, for developing the concept of Cases #1 and #2 in this exercise.

## Training Tool #9

### MINI-CASE STUDIES
FAULTY LISTENING HABITS

Please select from the following choices to identify the type of faulty listening habit(s) that each situation involves, and discuss a remedy for each:

- pseudo-listening
- selective listening
- insulated listening
- defensive listening
- insensitive listening
- stage hogging
- ambush listening

CASE #1

A residency program director is surrounded by six faculty members after a meeting, and each is making requests, comments, and suggestions. Although the director tries to listen, she is distracted by the number of people vying for her attention and does not remember half of what people are saying.

Type of faulty listening:
Solution:

CASE #2

A physician explains to a patient with high cholesterol that she will need to be on a statin medication on a long-term basis. The doctor asks his patient to return in six weeks for another cholesterol check because he wants to be sure that the medication is working and doesn't have side effects. After the patient's follow-up visit, the doctor sends the patient a letter saying that her cholesterol is at the target level. Several months later, the patient returns to the doctor's office and says she stopped taking the medication. Why? When she read the word "normal" in regard to her cholesterol level, she assumed that she didn't have to take it anymore.

Type of faulty listening:
Solution:

CASE #3

During a performance appraisal, the nursing supervisor tells an RN how much she appreciates the many improvements she has made during the past year. For example, the RN improved her communication, has been an excellent team player, and earned the highest possible scores for her clinical care as well as her relationships with patients and families. After the appraisal, however, the RN only remembers the one thing that her supervisor suggested that she work on: her ability to take criticism. The nurse complained to others that the evaluation was brutal and that her supervisor was way too hard on her.

Type of faulty listening:
Solution:

CASE #4

At a recent meeting, a health care association's executive director asked one of the vice presidents to give a report about a new project that would reshape how medical practices are organized. As she concluded a long, detailed explanation that focused on the financial aspects of the project, the vice president noticed that several managers stared at her blankly while others were yawning and fidgeting. "I'll wrap up my comments now," the vice president stated. "Do you all agree with my recommendations?" "What recommendations?" a manager asked.

Type of faulty listening:
Solution:

CASE #5

The director of the State Health Department agreed to meet with a group of disgruntled employees who were upset about her announcement of the need to make budget cuts. For about 30 minutes, she talked about the reasons for the budget cuts and ways to consolidate services so that no one's job would be jeopardized. No one said a word in response until the director specifically mentioned a project in which cuts might be heaviest. "Hey, that's my project," the employee said. "Will I still have a job?"

Type of faulty listening:
Solution:

**A physician's back is turned to the patient while entering electronic medical records (EMR) data**

## Training Tool #10

# Excuse my back

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Effective listening, improving patient relationships, customer service

**OBJECTIVES:**

- to illustrate the importance of active listening and appearing to be actively listening;
- to identify ways to compensate for communication obstacles caused by the use of communication technologies.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Distribute a copy of the case study to all participants and give them a few minutes to review the case either in all-group or small-group discussions

**DEBRIEFING:**

1 What were Dr. Donnay's conflicting priorities during this visit?
2 Given that the exam room was quite small and there may not have been room to put the EMR in another location, what could Dr. Donnay have done to avoid the impression that she was not listening to her patient?
3 If Dr. Donnay had been more proficient in using the EMR, would that have been enough to make the visit more satisfactory to Meryl Lowe? Why or why not?
4 What can physicians and other providers do to compensate for communication obstacles that result from using various technologies? What in particular can be done to improve listening skills in ways that enhance patient care as well as provider-patient relationships?

## Training Tool #10

### CASE STUDY: EXCUSE MY BACK

Having called at the last minute, Meryl Lowe felt fortunate to have even gotten an appointment today at the office of the Vineyard Medical Group. She tried to hold back the tears welling in her eyes and began to wring her hands as she anxiously waited for her physician, Dr. Charlotte ("Char") Donnay. For Meryl, it felt like an eternity. She felt a strong sense of relief the moment she heard a polite knock and saw her doctor enter the small exam room.

"I heard you want a gynecological workup today, Meryl. What's up? Has there been a problem?"

"Thanks for seeing me on such short notice, Dr. Donnay," Meryl said, now barely able to conceal her distress. "I'll tell you what has happened. It's awful. My life has completely crumbled in the course of one day."

Meryl sobbed as she explained that she just found out about her boyfriend's infidelity. Until the previous night, she had thought that she was in a monogamous, happy, relationship with Zin Van Dell, her housemate of the last three years. She believed Zin when he told her that he was working late several nights each week for the last few months. Then, last night, Zin told her that there was a possibility that Meryl might have an STD – compliments of "the other woman." And as Meryl learned, it was one of her supposed best friends, Kay Burnay.

"So in one day, I learned that my boyfriend has been unfaithful, and that his affair is with one of my best friends. To make it all worse, he tells me that I may have contracted a disease," Meryl tearfully explained. "I thought we were going to get married. Now, I don't know if I'll ever be able to forgive him. Or her . . ."

Dr. Donnay gave Meryl a quick hug. "Let's talk more about what happened in a little while. Let's do some tests and take care of the physical part first."

After Dr. Donnay asked several questions about Zin's symptoms and the tests were done, she rolled her stool closer to the computer next to the back wall to enter information about the tests into the new EMR. "I call it the Devil's software," Dr. Donnay joked. "No one here can figure the darn thing out. It will take a while, so please tell me more while I'm entering some data in here . . ."

"When I asked him if he loved Kay, he said he didn't know. I don't know if he'll leave me for her. Even if he doesn't, I don't know if I'll even let him back in the house . . ."

Dr. Donnay glanced over at Meryl and gave her a reassuring look. "Lots of women have gotten through things like this, Meryl. You can too. Grrr, this darn machine! Just a minute, I think I pressed something I wasn't supposed to . . ." Dr. Donnay felt somewhat guilty paying more attention to the EMR than her patient, but she didn't

want to leave the notes undone; due to the rigors of learning this new system, she was already 75 charts behind.

Meryl wasn't sure if she should continue with her story, or if she should wait until the doctor finished her computing. She watched the movements in Dr. Donnay's shoulders and back for signs that the writing had stopped.

"Go on, Meryl; I'm still listening," Dr. Donnay said, typing furiously.

When Dr. Donnay finished her notes, she swiveled around to face Meryl. "Okay, now we can talk. Sorry about that. Please go on and tell me what you're feeling."

For Meryl, the moment had passed. All she could think about was how much she wanted to get away.

"Never mind . . . just call me with the test results. I have to leave now."

## Training Tool #11

**A patient uses humor to subvert the discussion about her medical problems and lifestyle**

# Getting the patient's story

**TYPE:** Role play – physician and patient

**ESTIMATED TRAINING TIME:** 45 minutes

**THEMES:** Effective listening, improving patient relationships, customer service, managing patient expectations

**OBJECTIVES:**

- to learn the importance of identifying what patients say while getting additional clues from their nonverbal behavior and what they do not say;
- to identify ways to get past the smokescreens that disguise personal truths;
- to show how an effective listener can make patients feel safer in divulging personal information.

**MATERIALS NEEDED:** A copy of two roles for each dyad

**PROCEDURE:**

Start with a brief lecture on listening skills, with particular attention to questioning techniques and the importance of reading people's verbal and nonverbal cues to determine the direction of follow-up questions. Then distribute the two roles to each dyad so that each person is playing an opposing role. Allow about 10 minutes for the players to read their roles; although the physician's role won't take long to read, the patient's role is more detailed. When heads are up, announce that each dyad will have 15–20 minutes to complete the role play.

Variation: Consider dividing into groups of three, having the third person serve as observer. If you do this, don't show either instruction sheet to the observer.

**DEBRIEFING:**

At the end of the 15- to 20-minute time frame for the role play, bring participants back together for an all-group discussion. If you used observers, begin by asking them to report. Then ask:

1 What strategies did Dr. Harried use to get past Mrs. Donner's joking in order to get to the roots of her problems?
2 Was Dr. Harried able to convince Mrs. Donner to be less of a jokester in a confirming way so that she did not lose face or feel that she was getting a verbal hand slap? If so, what did Dr. Harried do?

3 Other than joking, what are some other examples of obstacles that physicians and other providers encounter when patients are reluctant to reveal certain truths about themselves?
4 What are the best ways to get past those obstacles so that patients feel comfortable telling their stories to you?
5 Did the doctor's questions uncover all of the medical issues in Mrs. Donner's fact sheet? (Ask those who played the role of the patient to share their instruction sheet with those who played the doctor's role.) If not, what could Dr. Harried have done differently? If all medical and underlying issues were uncovered, what types of questions and responses worked best?
6 How well did Dr. Harried convey active listening to the patient? At appropriate times, how well did Dr. Harried convey effective empathic listening?

## Training Tool #11

### ROLE PLAY: GETTING THE PATIENT'S STORY
CONFIDENTIAL INSTRUCTIONS

**Mrs. Roseanne Donner**

You are a 46-year-old mother of three who works three days per week as a server in a local coffee shop. You have been reluctant to see a doctor about your current problems, but your husband, Dan, insisted. Dan even took the morning off from work at his construction job so that he could bring you to the doctor's office.

A nurse just weighed you before bringing you into the exam room, and you were surprised to learn that you are now nearly 50 pounds heavier than you were during your last visit. You know that the doctor will tell you to diet and exercise, blah, blah, blah! In your mind, you'll get ready to diet as soon as Dan does, and that's never going to happen.

You take pride in having a wonderful sense of humor and often use your humor as both a weapon (to attack the other person in a joking way to keep them from attacking you) and as a defense mechanism (to deflect the subject so that people won't harp about your bad habits). Sometimes, though, you think you're funnier than other people do.

On this office visit, you do want to find out why you're having some troublesome symptoms, but feel reluctant to discuss them. You especially don't want to admit certain things about your lifestyle, as you're afraid that the doctor will tell you to give up several bad habits. Because you have little, if any, willpower, you do not want to be placed on a regimen that you won't be able to follow.

The amount you reveal during your visit will depend on the questions your doctor asks, how successful the doctor is at getting past your attempts at humor, and whether he/she makes you feel comfortable enough to reveal more about yourself. Start with "Stage 1" questions and reveal more in increments (in Stages 2, 3, and 4), depending on the quality of the doctor's questions and listening skills. Only reveal more if the physician's questions and comments would cause you to do so in real life.

Depending on what the doctor asks you, go to the appropriate section:

- symptoms
- diet and weight
- exercise and fitness

As you go through the stages on each issue, use your humor as a shield. Use only some of the humorous lines, as you won't have time to use all of them. Feel free to tone down the banter as you begin to open up so that you can keep the focus on the doctor's skills.

**Symptoms:**

Stage 1: Mention your frequent urination first. This is why Dan brought you to the doctor. He is tired of you hogging the one tiny bathroom in your house.

- "Sometimes I answer the phone by saying, 'Incontinence hotline . . . can you hold, please?'"

Stage 2: Next tell the doctor about your flu-like symptoms, mainly fatigue and weakness. You're sure that it's because you're working too much and picking up after your bratty kids.

- "As a housewife, I feel that if the kids are still alive when my husband gets home from work, then hey, I've done my job."*

Stage 3: Tell the doctor that you're often thirsty, but you think that's probably from all the pizza and salty foods you eat.

- "Once I was served a pizza and started sneezing like crazy, so I asked the waiter about the toppings. He said the topping was just what I ordered – pepper only."

Stage 4: If the doctor asks you the right questions and makes you feel comfortable, mention that you've been feeling pretty low lately and you've had frequent mood changes. If you feel especially comfortable, point out that you have low self-esteem.

- "Women complain about PMS, but I think of it as the only time of the month when I can be myself."*
- "Some people are going to leave a mark on this world . . . I'll probably leave a stain."
- "I don't suffer from insanity; I enjoy every minute of it."

**Diet and weight issues:**

Stage 1: Make jokes about your size:

- "I'm so big that when I lay on the beach, Greenpeace tries to push me back in the water."
- "Women should try to increase their size rather than decrease it, because I believe the bigger we are, the more space we'll take up, and the more we'll have to be reckoned with."*

Stage 2: You enjoy late night snacks – often raiding the refrigerator in the middle of the night.

- "I base my diet on the four essential food groups: fast, frozen, instant, and chocolate."
- "How is it that a two-pound box of candy can make me gain five pounds?"

Stage 3: Yes, you do drink . . . regularly.

- "I drink beer but that doesn't count."
- "Did you hear about the new bar drink that was invented by a gynecologist? It's a mix of Pabst Blue Ribbon Beer and Smirnoff Vodka. It's called a 'Pabst Smir.'"

Stage 4: How much alcohol do you drink? – You are reluctant to admit that you drink a six-pack or more every night; usually more.

- "It's not that I'm drunk all the time – I'm just over-served."
- "You're not drunk if you can lie on the floor without holding on."
- "I have a drinking problem . . . I can't afford it."
- "I'm starting to think that I drink too much. The last time I gave a urine sample, there was an olive in it."

**Exercise and fitness**

Stage 1: If the doctor asks if you exercise, start out with a joke:

- "I don't exercise at all. If God wanted me to touch my toes, He would have put them higher on my body."
- I don't work out because all the exercise programs start out by saying, 'Wear loose-fitting clothes.' I don't *have* any loose-fitting clothes!"
- "I'm in shape. A triangle is a shape."

Stage 2: Point out that when you're not at work serving food, you do a lot of running around at home: shopping for groceries and picking up after the kids and your lazy husband. It seems that no matter how much you clean, you can never keep up.

- "If you write in the dust in my house, please don't date it!"
- "Excuse the mess, but we live here."*

Stage 3: As you become more forthcoming, point out that what you mainly do all day is watch soap operas . . . except for the three days a week you work.

- "I'm getting tired of cable. Day after day it's the same 157 channels."
- "I don't understand why TV advertising is aimed at young people. It's older people like me who don't have the energy to leave the room during the commercials."

Stage 4: If you really feel like opening up, let the doctor know that you wonder if your lifestyle is killing you. Also mention that you don't think you have the willpower and strength to change.

- [No jokes on this one!]

*Quotations from comedienne Roseanne Barr. (Jokes without an asterisk are "author unknown.")

## Training Tool #11

### ROLE PLAY: GETTING THE PATIENT'S STORY
CONFIDENTIAL INSTRUCTIONS

**Jackie Harried, MD**

You are about to see a patient, Mrs. Roseanne Donner, and you're glad she's finally coming in for a visit. Mrs. Donner is extremely overweight, and you were surprised to hear from your nurse that on today's weigh-in, she is now almost 50 pounds heavier than on her last visit. You are worried about her condition, not only for her sake but also for those who depend on her: her husband Dan and their three children, all of whom are also your patients.

While you're looking forward to learning about the reasons for Mrs. Donner's visit, you expect that it will be quite a challenge to talk with her. It always is! Mrs. Donner tends to interject humor into her statements, almost like a protective shield, to keep you from knowing what she is really thinking and feeling. You will have to use your best listening and interviewing skills so that you can uncover what is really going on with Mrs. Donner's health and life.

You have been keeping a watchful eye on Mrs. Donner over the years to ensure that she doesn't have Type 2 diabetes; you suspected this years ago when you noticed symptoms, but tests came back negative. You also are concerned with Mrs. Donner's health habits. She has been quite cryptic about them during previous encounters, but you plan to explore them in more detail today.

In today's visit, you will take 20 minutes conducting the interview; this portion of the visit will not include the actual physical exam. You have blocked off this much time because it normally takes a while to get Mrs. Donner to feel comfortable enough to open up. And although her joking around can be quite tedious, you do admit that you find her rather amusing.

## Training Tool #12

**The temptations of interrupting patients too soon during patient interviews**

# True confessions

**TYPE:** Role play – physician and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Effective listening, improving patient relationships, customer service

**OBJECTIVES:**

- to show the importance of giving patients ample talk-time during office visits without unnecessary interruptions;
- to demonstrate the difficulties in maintaining an effective listen:talk ratio, particularly when a provider has an urge to coach or lecture.

**MATERIALS NEEDED:** A copy of two roles for each dyad

**PROCEDURE:**

Don't tell participants the real purpose of this exercise, which is to demonstrate the importance of not interrupting during the initial parts of the interview while patients are relating their stories. Rather, tell them that you would like the person who is playing the role of physician to practice their skills in learning about the patient's issues and problems.

Ask each participant to select a partner and distribute the roles so that one person in each dyad is the physician and the other is the patient. Announce that there will be a 15-minute time limit for the role play.

In the patient's confidential instructions, it is noted that you will send a signal by coughing or dropping a book three minutes after the exercise begins. Only those playing the role of patient will know that if the physician interrupts before this time, their role play is over.

**DEBRIEFING:**

1 How many of you were able to complete this exercise?
2 If you did not complete the exercise, what were the physician's reasons for interrupting the patient before three minutes? How much time transpired before the interruption? What details about the patient's story did the physician miss?
3 Is it possible that when we think of the word "interview," that implies a more verbal role for the provider in the beginning of the patient visit?
4 Under what circumstances would it be appropriate to interject comments or questions during the early part of the interview?

5 Studies have shown that the patient normally speaks for only around 18 seconds before the doctor interrupts, but that patients will tell you more about what is wrong with them if you allow them to speak for three or four minutes. Why do you believe it's advantageous to allow patients to tell their stories without interruptions?
6 What are some of the reasons that physicians and other providers might tend to interrupt patients sooner than three minutes? What can you do to overcome these urges?
7 What would you estimate is your normal listen:talk ratio in office visits? Does it vary from the beginning of the visit (i.e. the history taking) to the end? If so, how and why? What would be a more appropriate ratio?

## Training Tool #12

### ROLE PLAY: TRUE CONFESSIONS
CONFIDENTIAL INSTRUCTIONS

**Ina Tizzy, patient**

Although you were vague about the reason for your visit when you called for an appointment, you plan to tell the truth to Dr. Blabbowitz that you have been using illegal drugs. When Dr. Blabbowitz suspected this and confronted you about it on a visit a few months ago, you denied it and said you were stressed from work. You also lied on a previous visit when you told the doctor that your dilated pupils were from a visit to an ophthalmologist earlier that day. But now that you've hit rock bottom, you plan to tell the doctor everything.

Here are the details:

- It's true; you have been using illegal drugs – specifically crack cocaine – for about six months now and you believe that the situation has gotten out of control.
- You initially started smoking crack because you were curious about it, and also because many of your friends were using it. You liked crack immediately. It makes you feel euphoric, more alert and energetic. You also feel that you are much more powerful when you are high – sometimes even superhuman! Until you started using crack, the only drug you were taking was a medication that Dr. Blabbowitz had prescribed to you for esophageal reflux disease.
- While you know that it's normal for people to "crash" after the crack high is over – usually after approximately 20 minutes – your crashes have gotten increasingly worse. In addition to major depressions, you often experience cold sweats, nausea, and vomiting. Once you had a convulsion.
- Lately, you've had several other symptoms when you are not high: mood swings, restlessness, irritability, and paranoia. You sometimes think you hear voices, even when no one else is in the room.
- Because you have built up a high tolerance to the drug, it now takes a lot more crack for you to get high. Your habit is now approaching costs of $2000 a day. To get the money to support your habit, you have lied to family and friends and sold your house, car, jewelry, and stocks.
- Last month, you were fired from your job for "lapses in performance" and "numerous unexcused absences."
- The friend you have been living with since you ran out of money has now asked you to leave. You have nowhere else to go. Family members and friends that you have lied to and stolen from – virtually all of them – have told you that they want nothing more to do with you until you're clean for good.
- Having no income, no place to live, and no prospects for the future, you are more depressed than ever. More than once, you have thought about suicide.

- Right now, you have tremendous pain in your nose – you wonder if there is a hole in your septum. Other recent symptoms include tremors and muscle twitches.

**Important note:**

Unlike other role plays, this one has some special rules for your character:

1 As with all visits, the doctor will welcome you and speak with you casually to build the relationship and put you at ease. This is fine, but after the pleasantries, you will be playing by a different set of rules.
2 As soon as the doctor asks about the reason for your visit, *talk continuously*. Act as though you have no trouble at all continuing with your thoughts. You can use the points above to explain the drug problem and your concerns. Feel free to invent other parts of your history as long as the points are consistent with your character. *Don't stop talking unless interrupted!*
3 If the doctor interrupts you before three minutes are up, tell your partner that the role play is over and that he/she will find out the reason why when the facilitator calls for an all-group discussion. (To let you know when three minutes are up, the facilitator will cough loudly or drop a book.)

   An interruption will be defined as any comment by the doctor that interrupts the continuity of your comments and takes you into the doctor's direction rather than yours. For purposes of this exercise, it's all right for the doctor to make sounds, such as "Hmmm" or two to three word phrases such as "Really? What else?"
4 Regardless of whether you are able to complete this exercise, check your watch to see how long the physician allows you to talk before interrupting.

Remember: If your partner interrupts you before the facilitator coughs or drops a book, the game is over!

## Training Tool #12

### ROLE PLAY: TRUE CONFESSIONS

CONFIDENTIAL INSTRUCTIONS

**B. B. Blabbowitz, MD**

Your next patient is Ina Tizzy. Because Ina was somewhat vague when the receptionist asked about the reason for the visit, you are not quite sure why she is here. You just looked at your schedule and noted that you have a full 15 minutes that you can devote to her.

While treating Ina for esophageal reflux disease for the last several months, you noticed that Ina seemed somewhat hyper. She also had a slight temperature, high blood pressure, and an increased heart rate, but it was the dilated pupils in addition to the other symptoms that caused you to suspect illegal drug use. When you confronted Ina about this possibility, she denied it vehemently. She told you that she was extremely nervous about work and that there was a good reason for her dilated pupils; immediately before her appointment with you, she said that she had just seen her ophthalmologist for a routine eye exam.

You breathed a sigh of relief when Ina denied your suspicions; illegal drug use is a special concern of yours. Your interest in this topic began when your son developed a serious drug problem (heroin) approximately 10 years ago. After several months in a drug rehabilitation facility, your son has been clean ever since and, thankfully, he is now doing well in all facets of his life. Even so, the memory of how drug use almost claimed your son's life and how the problem disrupted your family is just as vivid today as it was back then. You don't want to see any other family go through such distress.

Even if you notice symptoms in Ina today, you will begin your visit with the usual pleasantries and try to put Ina at ease. How you proceed with the history taking and find out the real reason for Ina's visit is up to you.

Communicating with victims of sexual abuse

## Training Tool #13

# Behind closed doors

**TYPE:** Role play – physician and patient

**ESTIMATED TRAINING TIME:** 45 minutes

**THEMES:** Effective listening, improving patient relationships, confidentiality/privacy

**OBJECTIVES:**

- to identify ways that listening strategies should be modified when communicating with patients that you suspect have been suffering from sexual or other types of physical abuse;
- to demonstrate how listening strategies can be used to extract more information from patients, particularly those who feel guilt, embarrassment, or shame.

**MATERIALS NEEDED:** A copy of two roles for each dyad

**PROCEDURE:**

Distribute the roles to each dyad so that both persons are playing opposing roles: one as physician and the other as patient. Tell the group that they will have 20 minutes to conduct the role play, and that the group will then be reconvened for an all-group discussion.

**DEBRIEFING:**

1 How many of those who played the role of Dr. Kerralot were able to convince Shirley to open up about the sexual abuse she is suffering?
2 What questions did the doctor ask that helped Shirley to tell the truth? (Responses may include: Do you feel that you are in danger of being hurt or threatened? Does anyone hurt you? Do you feel safe in your relationship? How long has the violence been occurring? Have you ever been hospitalized because of the abuse? Can you tell me about your most serious event? Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you feel uncomfortable? Do you feel you are still at risk? How do you think the abuse has affected you emotionally and physically?)
3 Were any of the doctor's questions inappropriate? If so, which? Why?
4 Did the doctor address Shirley's psychological issues in addition to physical ones? Did the doctor address Shirley's safety needs? How effectively did the doctor address Shirley's feelings? How did the doctor address Shirley's concerns about confidentiality, that is, her husband's reactions if he finds out she "told"?

5 Of those who played the role of patient, what did the doctor do that facilitated your discussion? How would you assess the doctor's listening skills? What could the doctor have done differently?

6 In previous visits, did Dr. Kerralot help or hurt these interactions by saying that Shirley's story about getting bruised by falling was not believable?

7 In previous visits, did Dr. Kerralot do the right thing by not pursuing the subject of sexual abuse after Shirley made it clear that she didn't want to talk about it? Why or why not?

8 Should health professionals screen patients for domestic violence only when symptoms are present – or should all patients be screened, men as well as women? Please explain.

Note: A 1999 study published by the *Journal of the American Medical Association* (*JAMA*) revealed that fewer than 10% of primary care physicians routinely screen patients for domestic violence during regular office visits. Also, according to "The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings" [see http://endabuse.org], assessments for present and past victimizations should be "conducted routinely, regardless of the presence or absence of indicators of abuse."

9 Why do you think it often takes several visits before a victim of sexual abuse is willing to disclose the truth to a physician or another health professional?

10 How, if at all, would you address the subject of sexual abuse differently if the patient were a man?

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Many thanks to Karen Mitchell, MD, Director of the Providence Family Medicine Residency in Southfield, Michigan, for developing the concept for this case.

## Training Tool #13

### ROLE PLAY: BEHIND CLOSED DOORS

CONFIDENTIAL INSTRUCTIONS

**Primary Care Physician – Dr. Kerralot**

This will be your fourth visit with Shirley Cantell, a 26-year-old woman who has been married for one year. On earlier visits, she complained of various somatic complaints such as backaches, muscular soreness, headaches, and occasional abdominal pain. You conducted numerous tests – the ones she would allow you to do – but you could not pinpoint a diagnosis. She flatly refused a pelvic exam, saying that even the thought of such a test made her quite uncomfortable.

In addition to her refusal of a pelvic exam, you've noticed other red flags for sexual abuse during her past visits: she was not forthcoming about her history, she had dark purple bruising on her upper legs (she said she fell), and she was unwilling to talk about family planning/contraception. Each time you've asked her about the possibility of sexual abuse – you've tried to approach the subject in several different ways – she denied it vehemently. You've told her that you didn't believe her story about falling, adding, "If you ever do feel like talking about this, I'm always here for you."

On her last visit, Shirley began to open up a little more when she told you that being married wasn't what she had expected. She didn't tell you much about her husband, Riley, except that he is very stressed from work and wasn't himself lately. "It's almost as if he changed the minute we got married," she said. "But it's probably my fault. That's what he says anyway." When you sought details, Shirley seemed to become fearful; she said that she was exaggerating, that things were really fine at home, and that she didn't want to discuss the matter further. She added that she needs to work hard on being a better wife and loves her husband dearly.

On today's visit, Shirley will be seeing you about her worsening headaches, but you also plan to address your suspicions of sexual abuse in a way that will make her feel comfortable enough to tell you the truth about her situation. You've scheduled a little extra time for this visit in anticipation of an open discussion. As you formulate your questions to bring the problem to the surface, you will keep in mind that Shirley is not only afraid and embarrassed, but also that she feels responsible for the problems in her marriage. You have dealt with victims of sexual abuse numerous times before, and you know the importance of addressing this delicate subject with great sensitivity.

## Training Tool #13

### ROLE PLAY: BEHIND CLOSED DOORS
CONFIDENTIAL INSTRUCTIONS

**Patient – Shirley Cantell**

As a 26-year-old woman, you know that you should be having regular gynecological exams, but you have refused this during each of four visits with your new primary care physician, Dr. Kerralot. You pointed out that such an exam would be much too stressful for you, and that you would allow any other test but that one.

The reasons for your past visits to Dr. Kerralot were to seek help for numerous symptoms that have caused you a great deal of pain: frequent headaches, backaches, soreness in your muscles (especially in your arms and lower extremities), and occasional abdominal pain. You've also had extreme bruising in your groin area, with the purplish tint of the bruises extending down your upper legs. When Dr. Kerralot asked about the bruising, you said that you fell and strongly denied being sexually abused. The doctor respected your wishes not to discuss the matter further and said, "I don't believe that you fell, Shirley. If you ever do feel like talking about this, I'm always here for you."

On your last visit, the subject of your one-year marriage came up, and you did mention that being married has not been what you expected. You told Dr. Kerralot that you love Riley deeply, but he is often stressed from work. "It's almost as if he changed the minute we got married," you said, adding that Riley has convinced you that the problems in your marriage are your fault and that you add to his stress because you are not a better wife. When the doctor asked more questions about it, you started to think about what Riley would do if he ever found out you discussed these matters with an outside party. You told the doctor that you didn't mean what you said and that things were actually fine at home.

In truth, however, things are not fine. Riley swears and screams at you, makes demeaning remarks about your body, physically attacks you, and forces you to act out pornography. The word "no" means nothing to Riley; he feels that being married gives him license to treat you any way he wants. When you don't abide by Riley's wishes, the sex becomes even rougher and he often hits you in the chest, face, and stomach. On one occasion, he choked you so hard that you completely lost consciousness. If only you could be a better wife!

Today, your major complaint is the increasing severity of your headaches. They are so bad that you sometimes become nauseous. You also have a few new problems: frequent indigestion and diarrhea. If only you could get relief from these symptoms, you feel that you would be a better wife to Riley so that he wouldn't get so mad.

Will you admit to Dr. Kerralot during today's visit that you have been a victim of sexual abuse? That depends. If the doctor asks you in a nonjudgmental way that

makes you feel safe in revealing the information, you probably will. If you do, you'll reveal the information in stages, a little at a time. In addition to being quite embarrassed and fearful about discussing this (and feeling that you're largely responsible for Riley's behavior), you worry about what Riley will do to you – and perhaps the doctor – if he ever found out that you told.

# Improving patient relationships

## Training Tool #14

**Identifying the components of effective relationships with patients**

# Effective patient relationships

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to define an effective patient relationship;
- to demonstrate that effective relationships with patients involve all personnel.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

As you introduce the subject for this training session, ask, "What does an effective patient relationship mean to you? What are the components of these relationships?" Write the responses on a flip chart. Answers may include: trust, mutual respect, open communication, patient satisfaction, patient compliance, etc.

Then ask participants to identify the various points of contact when patients would be likely to notice the quality of the relationship with their provider and the office as a whole. Responses may include: telephone communications with patients (to schedule appointments or answer questions); the manner in which patients are greeted and treated during check-in and check-out; communication during the exam; office systems and policies that support good relationships; responsiveness to patients' reports of problems; follow-up phone calls; etc.

**DEBRIEFING:**

Referring to the list, point out that all members of the practice play a key role in patient communications – even those that do not have direct patient contact.

**Identifying communication problems that can damage relationships with patients**

## Training Tool #15

# Patient relationships: what not to do

**TYPE:** Demonstration – provider and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVE:**

➥ to demonstrate how errors and omissions in communication can adversely affect relationships with patients.

**MATERIALS NEEDED:** One copy of each instruction sheet (for each of the two volunteers)

**PROCEDURE:**

Ask for two volunteers to engage in an improvisation about the beginning of a patient visit. Designate one to play the role of patient, the other as provider (e.g. a physician, nurse, or physician assistant), and give each a copy of their role. Allow a few minutes for the volunteers to read their instructions and think about how they will act out the scene. Then give the volunteers these instructions:

➥ use your best acting skills – but try to make this as "real life" as possible;
➥ speak loudly enough so that all members of the group can hear;
➥ feel free to improvise other negative behaviors in addition to those listed;
➥ humor is most welcomed!
➥ please time this so that your scene is no longer than 10–15 minutes. The remaining time will be devoted to an all-group discussion.

**DEBRIEFING:**

1 How would you characterize what happened in this scene?
2 What was good about this interaction, if anything?
3 What did the provider do or not do that may have caused this relationship to deteriorate?
4 How should the provider have behaved or communicated differently?
5 What could the provider do to improve this relationship in the future?

As the group discusses what the provider could have done differently, be sure they have noted that the provider needed to:

♦ review the chart before entering the room;

- make a personal connection through warm and direct eye contact, particularly upon entering;
- give an appropriate greeting;
- refer to the patient by name;
- ask how the patient is, rather than "What's the problem today?";
- communicate with the patient at eye level;
- avoid interrupting when the patient describes the chief complaint;
- ask probing questions, including a question about the psychosocial issues that the patient alludes to;
- ask, "Anything else?" to avoid last minute "door-knob" questions;
- use the patient's discussion about health information in the tabloids as an opportunity for a "teachable moment."

## Training Tool #15

### DEMONSTRATION

PATIENT RELATIONSHIPS: WHAT NOT TO DO

**Confidential Instructions**

**Patient**

Thank you for participating in this demonstration! In this exercise, you will play the role of an irritated patient. The other "actor" in this demonstration (the provider) is being instructed to demonstrate what not to do during a patient care visit, and you are the patient who suffers the consequences.

Throughout the role play demonstration, feel free to show – verbally and nonverbally – when something is upsetting you, such as when the provider does or says something that makes you feel hurried or disconfirmed.

This is an improvisation, so please make up the scene as you go along. Here are some guidelines:

- You are quite annoyed, as you have been waiting almost 45 minutes in the reception area, and 15 more minutes in the exam room.
- You've been seeing this provider for five years and expect to be recognized.
- You are coming in today to have the provider look at the rash on your forearms that emerged during a camping trip with your children. Complain about the intense itching.
- When the provider interrupts as you're describing your complaint, don't give much more information. Only respond to questions asked.
- As a side issue, mention to the doctor that you have been very depressed lately. (For example, "I've been so down-in-the-dumps lately, I can barely get out of bed.")
- You're a big fan of the tabloids, and you mention some outrageous "health tips" you've read (e.g. "I just read that drinking one liter of red wine each day will protect me from heart attacks!").
- Just before the end of the visit, mention several other last-minute problems (e.g. you've felt "flushed" lately; you have a sore knee, etc.).

## Training Tool #15

### DEMONSTRATION

PATIENT RELATIONSHIPS: WHAT NOT TO DO

**Confidential Instructions**

**Provider**

Thank you for participating in this demonstration! Your purpose is to demonstrate what not to do during a patient care visit. Please make up the scene as you go along. Here are some guidelines:

- You haven't reviewed the charts before you entered the room, and you can't remember this patient. You've drawn a total blank!
- During the visit, act hurried; keep looking at your watch and nod your head a lot when the patient is speaking – as if to say "Let's get this over with."
- Don't say hello. Don't use the patient's name.
- Don't look at the patient when you enter the room – look at the charts instead.
- Don't apologize for the patient's wait.
- Say, "Okay, what's the problem today?"
- Hover over the patient to demonstrate authority and dominance.
- When the patient starts to describe the reason for the visit, interrupt within five seconds or so.
- When the patient mentions being depressed, ignore it; focus instead on the rash.
- When the subject comes up, tell the patient that tabloids are stupid.
- Get very annoyed when the patient describes several last-minute complaints.

**Identifying what's wrong in a scene about communication between patients and personnel**

## Training Tool #16

# Cool reception

**TYPE:** Three-act play – four "actors"

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service, confidentiality/privacy

**OBJECTIVES:**

- to raise awareness about perceptions that are created about the practice by personnel when greeting patients and handling necessary tasks;
- to identify ways to improve greetings and the handling of financial matters at the beginning of patient visits.

**MATERIALS NEEDED:** A copy of the scripts for each of the four volunteer "actors"

**PROCEDURE:**

Ask for four volunteers to serve as "actors" and assign one of the following roles to each:

- Receptionist – Ginger Curry
- Patient 1 – Herb Basil
- Patient 2 – Rosemary Sage
- Nurse – Anise Peppercorn, RN

Distribute a copy of the script to each actor and give them a minute or two to look it over. Point out that their stage directions appear in brackets.

Next, tell observers that while they watch a brief three-act play, they should jot down whatever they notice that is not effective in building or maintaining effective patient relationships. Note that there will be a brief group discussion after each scene.

**DEBRIEFING:**

Ask the following questions between each "act."

Act 1

1 Did it seem that some of the characters in this scene need a little "seasoning"? [Expect groans.]
2 What, if anything, was good about this scene? (The receptionist did handle her co-pay and insurance tasks, and she did work Mrs. Sage into the schedule.)

3 What problem areas did you notice?

In the interaction between Ginger and Mr. Basil:

- Ginger was engaged in a personal phone conversation while a patient was waiting;
- she showed irritation at being interrupted by the patient;
- she didn't use direct and warm eye contact;
- she didn't greet the patient or make any personal connection;
- her focus was on the co-pay and insurance (i.e. the paper more than the person);
- she quickly dismissed Mr. Basil's question about the schedule.

In the interaction between Ginger and Mrs. Sage:

- by not explaining the reason for Dr. Parsley's unexpected absence, she made it seem as if the doctor was irresponsible or uncaring;
- she announced personal information (the "infection") as she called to Mrs. Sage in the reception area.

Act 2

1 What, if anything, was good about this scene? (The nurse fulfilled her tasks and escorts the patient to appropriate rooms.)
2 What problems did you notice?
   - The nurse called Mrs. Sage by her first name, "Rosemary."
   - The nurse does not respond to Mrs. Sage's comment about not doing well, seeming more interested in the task than the person.
   - The nurse seems surprised at the patient's weight gain.
   - The nurse asks the patient to go to the bathroom for her. For *her*?
   - The nurse interrupts as the patient is objecting to disrobing completely.
   - The nurse calls Mrs. Sage "sweetie," which is not respectful.

Act 3

1 What problems did you notice in this scene?
   - Ginger did not apologize for the wait.
   - She did not seem to know that Mr. Basil was a long-term patient.
   - She did not refer to him by name.

## Training Tool #16

**THREE-ACT PLAY**
COOL RECEPTION

CAST:
Receptionist – Ginger Curry
Patient 1 – Herb Basil
Patient 2 – Rosemary Sage
Nurse – Anise Peppercorn, RN

* * *

**ACT 1**
**Setting: Front desk and reception area. Situate three chairs so that one is for the receptionist and two chairs are across the room, representing the reception area.**
[Ginger is seated at the front desk and the sliding window is closed. She is talking on the phone and laughing.]

Mr. Basil
[Knock on the window]
Excuse me! Hello? Ahem, excuse me. Ahem!

Ginger
[Continue to ad lib talking on the phone; you don't hear Mr. Basil]

Mr. Basil
[Louder]
Hello?? I have an appointment! I NEED TO CHECK IN!

Ginger
[Finally open the glass window, but show that you are disturbed at the interruption; don't give the patient much eye contact.]
Yes?

Mr. Basil
I'm Herb Basil. I have an appointment at 10:30 with Dr. Lantro.

Ginger
[Tell the person on the phone that you'll call back later]
Well, did you sign in? You're supposed to sign in.
[Ginger motions to the sign-in sheet and closes the window.]

Mr. Basil
[Knock on the window again]
Hello, miss?

Ginger
[Getting irritated, opening the window again]
What? Oh, wait a minute . . . you didn't pay your co-pay. That will be $20.

Mr. Basil
[Hands her the money]
I have a pretty full day today, and I just wondered if the doctor is running on time.

Ginger
No one has told me. Has your insurance changed?

Mr. Basil
No, it's the same.
[Ginger closes the window again. Mr. Basil sits in a reception chair. Mrs. Sage enters and walks up to Ginger.]

Mrs. Sage
Hello, I'm Rosemary Sage and I have an appointment with Dr. Parsley.

Ginger
[Opens the window]
He's not here today.

Mrs. Sage
WHAT? But I have an appointment! You have me down in your schedule to see Dr. Parsley, don't you?

Ginger
Dr. Parsley didn't come in today.
[Look at the schedule]
I can get you in with Dr. Sal Lantro, though. Just sit down and I'll call you. But first I need your $20 co-pay.
[Mrs. Sage pays, then shakes her head in disgust and sits down next to Mr. Basil in the reception area.]

Ginger
[Open the window]
Rosemary? Are you here about that infection?

Mrs. Sage
[In disbelief]
Excuse me?

Ginger
[Acting as if Mrs. Sage is hard of hearing]
Are you here about the INFECTION?
[Anise opens the door to the hallway]

Anise
Rosemary? Dr. Lantro will see you now.

* * *

**ACT 2**
**Setting: Hallway and exam room.**

Anise
How are you doing, Rosemary?

Mrs. Sage
Not too well, I'm afraid.

Anise
This is about an infection, right?

Mrs. Sage
It's a bad sore on my forearm. I didn't realize it was infected.

Anise
All right then. Rosemary, come over here and let me take your weight.
[Mrs. Sage stands on the scale]

Anise
Wow! Oh my goodness, I need to move this to another level!
[She adjusts the scale]
[Loudly]
OKAY, CAN YOU GO TO THE BATHROOM FOR ME NOW? I NEED A SAMPLE!

Mrs. Sage
Not at the moment.

Anise
Okay, Rosemary, maybe you can "go" for me a bit later. Now follow me, go right in here, take off your clothes – you can leave your socks on – and put on this gown.

Mrs. Sage
Take off all my clothes? But I just need . . .

Anise
It's the procedure, sweetie. You know the drill. The doctor will be with you shortly.

* * *

**ACT 3**
**Setting: Back in the reception area.**

Mr. Basil
[Walk to the front desk]
Excuse me! Do you know I've been sitting here waiting for 45 minutes?

Ginger
That's about par for the course around here.

Mr. Basil
I had an appointment with Dr. Lantro, and yet you took that other patient first and I heard that she was here to see Dr. Parsley!

Ginger
Well, that doctor isn't here.

Mr. Basil
This is ridiculous.

Ginger
Are you a new patient?

Mr. Basil
NO, are you a new employee? I've been coming here for 20 years!

Ginger
The best advice I can give you is to just be patient and wait. We'll call you shortly.

Mr. Basil
I don't feel very "patient" right now.

**Identifying ways to improve patient relationships by communicating between visits**

## Training Tool #17

# Between visits

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVE:**

➥ to identify ways to enhance patient relationships by communicating between visits.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Ask participants what a medical practice can do to build patient loyalty between office visits – whether the patients visit the office regularly or come in every few years. List the responses on a flip chart.

Likely answers include: making occasional calls to find out how patients on new treatment plans are progressing; sending greeting cards on holidays and birthdays; sending reminder notes for scheduled visits; sending schedules of when preventive services are suggested (e.g. Pap smears, mammograms, and cholesterol checks); developing bill-stuffers with health tips; distributing a periodic office newsletter; and attending community events to see patients and their families in different settings.

**DEBRIEFING:**

1 Because some patients tend to switch to another practice due to insurance coverage, a move to another community, and other factors, is it worth it to make efforts to build patient relationships these days? Why or why not?
2 Why do you suppose that many medical practices do not contact their patients between visits? What would be the benefits of doing so?
3 Which of the ideas listed on the flip chart do you think would be most appreciated by patients? Which would be the most practical? The most affordable?
4 Is there a downside to contacting patients between visits? If so, give some examples. Do the advantages outweigh the disadvantages? Please explain.
5 What else can medical practices do to become more patient-centered?

## Training Tool #18

# Anxious moments

**Factors that may result in a patient's anxiety at various stages of an office visit**

**TYPE:** Worksheet

**ESTIMATED TRAINING TIME:** 60 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to identify factors that may trigger anxiety from the patient's perspective;
- to determine strategies that will ameliorate patient anxiety by addressing these factors.

**MATERIALS NEEDED:** A copy of the worksheet for all participants

**PROCEDURE:**

In a brief lecture, note that many patients are fearful or anxious during visits to a medical office. Reactions can range from mild (normal nervousness about seeking care) to more extreme reactions such as iatrophobia (fear of doctors) or dentophobia (fear of dentists), which causes obsessive worrying, sometimes to the point of avoiding care, even for serious problems.

While noting that most patients have reactions in the mild to moderate range, ask: "What are the likely effects of anxiety on the patient? What are possible effects on their health and well-being?" Possible answers include: it may color their impression of the visit; they are likely to be less satisfied; they may forget to ask important questions; they may misinterpret the provider's advice; and the provider could mistake their symptoms of anxiety – clammy hands, sweating, rapid breathing, rapid heartbeat, nausea, and dizziness – for other types of medical problems.

After this discussion, distribute a copy of the worksheet to all participants. Divide participants into small groups of four to five people, and offer the following instructions:

> "Now that we've discussed the adverse effects of patient anxiety, let's examine what may trigger the patient's anxiety at various stages of the office visit. We'll start with events leading up to the visit, and conclude with the end of the exam.
>
> The left column of the worksheet describes selected locations or events. In the middle column, please list anything that is likely to trigger patient anxiety – even the slightest amount. In the last (third) column, please list anything that could be done within the office – either through communication, procedures, processes,

policies, changes in office design or set-up, etc. – to ameliorate that anxiety. Feel free to leave some of the boxes blank; after all, there are likely to be some parts of the visit that do not evoke an anxious response. But when you do list a trigger for patient anxiety, think out-of-the-box to consider anything that would be a stress-reliever. You will have 35 minutes for your group to list its responses."

**DEBRIEFING:**

1 Was it surprising that that there would be as many stressors during the course of an office visit? Why or why not?
2 What are some of the things that could go through a patient's mind before the visit, when noticing symptoms and making an appointment? (Responses may include: Are my symptoms serious? Will I have to wait days, weeks, or months for an appointment? Have they forgotten me while being put on hold? Should I discuss my problem with a non-clinician? Will I catch an illness from those waiting in the reception area?)
3 What might trigger anxiety during the visit itself? (Responses may include: divulging personal information, feeling undignified when disrobed, fearing pain or discomfort from a test, fear of needles, the anxiety of waiting for test results, concerns about possible negative outcomes from the exams or medical procedures, concerns about having a serious condition, being told of the need to change health habits, concerns about hospitalization, and concerns about costs.)
4 What sights, sounds, and smells are likely to contribute to patient anxiety during the visit?
5 Did your group notice other junctures during the visit that may trigger anxiety? If so, please explain.
6 How can a patient's anxiety be triggered by what they hear from external sources prior to the visit? (Examples may include: horror stories that the patient hears about diagnoses or treatments from friends and family members; being frightened by sensational medical stories they read in the tabloids; and not understanding information about symptoms and medical conditions that they read about on the Internet.)
7 What anxiety triggers would be different (or greater) for a child than an adult patient?
8 What additional factors would trigger patient anxiety in a hospital setting?
9 Which of the solutions that your group recommended would be worth trying?

## Worksheet: Anxious Moments

| Component of office visit | What the patient might be anxious or fearful about at this point | What can be done to reduce or eliminate the source of anxiety? |
|---|---|---|
| **Before the visit** | | |
| The patient develops symptoms and identifies the need for an office visit. | | |
| The patient calls for an appointment. | | |
| The patient is put on hold. | | |
| The receptionist asks the reason for the visit. | | |
| **Entering the office** | | |
| The patient enters the office; several people are waiting in the reception area. | | |
| The patient signs in and speaks to front desk personnel about insurance and co-pay. | | |
| The patient sits down in the reception area and waits to be called. | | |
| **The exam room** | | |
| A nurse escorts the patient to an exam room and does preliminary tests: weight, temperature, blood pressure | | |

| Component of office visit | What the patient might be anxious or fearful about at this point | What can be done to reduce or eliminate the source of anxiety? |
|---|---|---|
| The nurse questions the patient about the reason for the visit. | | |
| The nurse shows the patient to a nearby rest room and requests a urine sample. | | |
| The nurse asks the patient to undress and put on a gown | | |
| The nurse leaves the room; the patient is alone and undresses. | | |
| The patient is seated on the edge of the exam table, draped in the gown, and looks around the room. | | |
| The provider enters the room and greets the patient. | | |
| The patient describes symptoms and concerns that created the need for the visit. | | |
| The provider interviews the patient. | | |
| The provider performs a physical exam. | | |
| The provider describes the diagnosis and treatment. | | |

| Component of office visit | What the patient might be anxious or fearful about at this point | What can be done to reduce or eliminate the source of anxiety? |
|---|---|---|
| The provider writes prescription orders and explains how to take medications. | | |
| **End of visit** | | |
| The provider leaves, and the nurse or medical assistant returns to carry out orders, e.g. vaccines, EKG, or test for infection. | | |
| The patient waits while the provider reviews results. | | |
| The patient hears the test results. | | |
| The patient goes to the check-out area to make payment and/or schedule the next appointment. | | |

**A physician's attempts to welcome, inform, and calm a fearful patient**

## Training Tool #19

# Lucky you

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to demonstrate the need for "safe" topics when meeting the patient and exchanging pleasantries;
- to show that patients may interpret a health professional's innocent comments as having meaning about their prognosis;
- to illustrate the pitfalls of explaining conditions that have not yet been confirmed.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

To set the stage for this case study, point out that the dynamics in physician-patient relationships have changed dramatically over the years, from a paternalistic, physician-centered approach to a more equal, patient-centered model. But while many providers today feel fortunate that they are no longer placed on such high pedestals by their patients – in favor of a physician-patient partnership – don't forget that patients still hold their providers in high regard for their knowledge and expertise. As such, they are still apt to take anything that the provider does or says quite seriously, as this case study indicates.

After distributing the case study and giving participants a few minutes to read it, lead the group in a discussion about the questions below.

**DEBRIEFING:**

1 What is your opinion of the topics that Dr. Merryweather chose to discuss with Helena during their first meeting? Giving him the benefit of the doubt, do you think that he assumed that since he and Helena were the same age, they would both be mourning the passing of James Accord, the famous folksinger?
2 Was it reasonable for Helena to think that Dr. Merryweather's comment about James Accord was directed at her? Why or why not?
3 Why do you think patients tend to take any comments from their providers – even casual ones – so seriously?

4 Do you agree with the way Dr. Merryweather tried to calm Helena's fear about the biopsy results? Why or why not?
5 What could Dr. Merryweather have done differently in order to keep Helena from thinking the worst?
6 Was it better for Helena to know the hopeful information about her possible prognosis in advance (so that she'd have less to worry about) – or to wait for the biopsy results before discussing endometrial cancer?
7 What, if anything, would have helped Helena deal better with the two-week wait for the biopsy results?
8 Why do you think Helena vowed never return to Dr. Merryweather's office even though she knew he is highly regarded by Dr. Austin and others?

## Training Tool #19

### CASE STUDY: LUCKY YOU

The minute Helena Beall noticed vaginal bleeding, she knew there was a problem; after all, it had been several years since she went through menopause. She ran to the phone and called her family physician's office. Hearing her symptoms – and the urgency in her voice – the receptionist agreed to work her in the schedule that same afternoon.

Dr. Harry Austin did a gynecological exam and didn't see anything unusual. But just to be sure, he ordered a sonogram for Helena at a nearby diagnostic center. A few days after the testing was done, Helena returned to Dr. Austin's office for a follow-up visit.

"The results from your sonogram came back as 'suspicious,'" Dr. Austin said. "While I still don't think it's anything major, we need to be sure. I'm going to refer you to an OB-GYN colleague of mine, Dr. Chad Merryweather, and have him do an endometrial biopsy. He's an outstanding doctor and excellent diagnostician. I feel extremely comfortable referring you to him."

Dr. Austin's nurse made an appointment for Helena at Dr. Merryweather's office and sent him the sonogram results as well as the notes from Dr. Austin's exams. On the weekend before her appointment, Helena attended a dinner party with several friends and entered the kitchen to bring in dishes she helped to clear. The party's hostess, her friend Andrea, was loading the dishwasher.

"You don't need to worry about an endometrial biopsy," Andrea said. "I've had three of them. I won't lie; it's not a pleasant procedure and, yes, it does hurt. But it only takes a second and then it's over. Don't worry about it!"

Helena played back Andrea's advice in her head several times in a futile attempt to calm herself. She was worried about having a painful procedure, but was far more concerned that Dr. Merryweather would find a problem. A bad problem. She felt that she could take any news at all – as long as it wasn't the "C" word.

The night before her exam, Helena barely slept. She imagined herself in various scenarios, as if she were in a screenplay about her life. How would she look when Dr. Merryweather tells here that it's all clear – no cancer at all? Jubilant! Helena's thought process was shattered as she thought of another possible future. If there was bad news from the biopsy, she would surely fall apart.

Dr. Merryweather's nurse was a lovely young lady with blonde hair pulled back into a 1950s ponytail. She had a sweet, calming voice. "Helena, I promise, there is nothing to worry about! This procedure will be over before you know it."

The nurse proceeded to ask a few questions. "Any changes in your weight?"

"Oh yes, I've lost about 10 pounds."

"Has your weight loss been recent?"

"Yes," Helena said proudly. She didn't mention how hard she worked to take off these unwanted pounds because she didn't think it was relevant.

"Oooohhhh," the nurse said, biting her top lip as she jotted notes. "And I see on the chart that you had vaginal bleeding, right?"

"Yes. That's when I went to see Dr. Austin. He sent me for a sonogram and it came back 'suspicious.' That's what brought me here."

As the nurse's face tightened, her smile morphed into a look of concern. "Dr. Merryweather is a great doctor. He has reviewed your sonogram results, and he'll be here shortly to talk with you for a few minutes before he does the biopsy. Are you okay?"

Helena felt slightly comforted, hearing yet again about Dr. Merryweather's talents.

"Yes, I'm fine. Thanks." Still, she wondered if the results of today's test would change her life.

Moments later, Dr. Merryweather entered the room. His smile put Helena at ease immediately. With Helena's medical records in his hand, he sat in a chair across the room and opened the chart.

"It says here that you're 57-years-old, Helena."

"That's correct."

"Well I'm 57 too! And do you know who else was 57? James Accord, the famous folksinger from the 70s. He died yesterday. I think 57 is too young to die, don't you, Helena?"

"Yes I do!" Helena replied adamantly. She was aghast that this would be the topic that Dr. Merryweather chose to address during the first minutes of their meeting.

After explaining his love for James Accord's music, Dr. Merryweather easily moved to other topics – current events, the weather, and Helena's symptoms – but Helena's mind was locked onto the phrase, "I think 57 is too young to die, don't you, Helena?" None of the doctor's other statements even registered.

Helena replayed the statements heard during the last few moments in her mind. *Dr. Merryweather's nurse seemed concerned about something. Dr. Merryweather has seen my sonogram results, and then mentioned death in the first few seconds of meeting me. Is he trying to prepare me for the worst?*

"I'm worried about what you're thinking from the results of the sonogram," Helena said. "I've been terrified of cancer."

"Well Helena, no matter what happens, you are very lucky. If you have to have cancer, endometrial cancer is the type you want to have. We have more than an 80% cure rate! Depending on what we find from today's biopsy, we'd take out the malignancy, which may or may not involve a hysterectomy. Then you'd have chemo, possibly radiation, and we'd follow you carefully to be sure we got it all and it doesn't ever come back. I'm telling you, Helena – you don't have to worry even if we do find something. Like I said, if you have to have cancer, THIS is the type to have!"

"Lucky me," Helena said, her eyes brimming with tears.

Andrea was right; the biopsy wasn't pleasant, but mercifully brief. Dr. Merryweather

sounded happy as he announced that he had "a good sample" and told Helena that she could find out the results in two weeks.

For Helena, the next 14 days were practically unbearable. Each night, it took her forever to fall asleep, and she woke up several times each night. When friends and family asked Helena why she was so certain she'd hear bad news, Helena recounted the conversation with Dr. Merryweather.

*"I think 57 is too young to die, don't you, Helena? . . . If you have to have cancer, THIS is the type to have!"*

Hearing this account of her doctor's visit, friends and family agreed that Helena had every reason to be concerned. On the 13th day after the biopsy, Helena stayed home from work and wrote her obituary.

On day 14, Helena received a call. "Hello, Helena? This is Dr. Merryweather's nurse. We just got the results back from your biopsy. You're fine, it's just endometrial thickening. Just make an appointment for a routine pelvic and Pap smear in about a year."

A year later, that's exactly what Helena did – but under another doctor's care.

## Training Tools #20–4



# Case studies on improving patient relationships

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 45 minutes (2 cases)

**THEMES:** Improving patient relationships, customer service, managing patient expectations

**OBJECTIVES:**

- to identify strategies for improving relationships with difficult patients;
- to show the need to modify strategies depending on the type of difficult behavior.

**MATERIALS NEEDED:** A copy of two selected cases for all participants

**PROCEDURE:**

Begin the session with a discussion about the special needs of "difficult" patients: those who are emotionally needy, physically distressed, rude, impulsive, overly anxious, etc.

Break the group into teams of four or five persons. As you distribute two case studies selected from the following list, ask each team to allow around 15 minutes for a discussion on each case. Note that one person from each group will be asked to report to the group as a whole on the team's responses to the questions that appear after each scenario. Your options are:

- **Love me, love me not** – A patient confuses appreciation with love for her provider.
- **Drama queen** – A patient exaggerates symptoms to get a provider's attention.
- **The maddening patient** – A rude, obnoxious patient tests a physician's impulse control.
- **The worried well** – A somatic patient makes numerous appointments for overblown concerns.
- **Social hour** – A lonely, elderly patient makes appointments to fill her day.

**DEBRIEFING:**

1 What were your group's responses to the questions following each case?
2 Were the strategies your team suggested similar for each of the two cases, given that

the patients were both “difficult”? Or did you develop strategies that were specific to the type of difficult behaviors in each case?

3 In these cases involving problem patients, was your main concern to resolve the issue at hand, improve or clarify the provider-patient relationship as a whole, or both? What different strategies would be required for each of these objectives?

4 Did a power differential or other dynamics between provider and patient play a role in these cases? Please explain your response.

## Training Tool #20

### CASE STUDY: LOVE ME, LOVE ME NOT

Dr. Bob Border is a divorced male physician who has been treating and counseling a distraught female patient, Lola Brigitta for the weight loss, headaches, depression, and panic attacks that Lola has experienced since her husband passed away unexpectedly six months ago. During the last few visits in Dr. Border's office, Lola noted that her panic attacks are occurring less frequently, her headaches are becoming less intense, and her depression is slowly lifting. With great enthusiasm, she credits Dr. Border with these major improvements.

While Dr. Border has been delighted with Lola's progress, he became concerned when he received a lovely large houseplant from her for his birthday. Did this represent a potential problem – or was it simply an expression of appreciation by a grateful patient? He sent a note to Lola thanking her for the kind gesture, feeling a little ashamed of having suspicions.

Dr. Border is now meeting with Lola and his initial instincts have just been confirmed. She is dressed in a suggestive manner and is acting flirtatiously, having just touched Dr. Border's forearm and leaving her hand there for seconds too long. After rambling for a few minutes, she confessed that she is falling in love with him. Tearfully, she offered to find another doctor if he is interested in her as well.

While Dr. Border is not interested and strongly believes that a relationship with either a current or former patient is inappropriate, he wants to be careful how he addresses this matter with Lola so that he doesn't aggravate her ongoing symptoms. On the other hand, he wants to be firm and direct so that his position is crystal clear.

### DISCUSSION QUESTIONS

1 Should Dr. Border have sent back the houseplant? Why or why not? Would a gift be acceptable by grateful patients in other circumstances?
2 What should Dr. Border say to the patient during this visit? What should his nonverbal behavior be? What can he do or say to establish boundaries?
3 Should Dr. Border mention Freud's concept of transference – that she is projecting her feelings from other men in her past (e.g. her departed husband) to her physician? Or if he mentions that she is transferring her emotions to the person who has helped her – thus mistaking gratefulness for love – is she likely to feel that he is dismissive of her feelings? Might she experience a loss of face, embarrassment, and/or resentment? How could Dr. Border prevent or mitigate such reactions?
4 Should Dr. Border send a follow-up letter to reiterate his concerns? Why or why not? If so, what should be the tone of the letter?

5 Should Dr. Border advise this patient to select another physician? Why or why not?
6 Would a doctor or another health professional handle a situation like this differently if the genders of the two parties were reversed (i.e. a female provider and male patient)? If so, how? What if the provider and patient were of the same gender?

## Training Tool #21

### CASE STUDY: DRAMA QUEEN

Bette Mavis, a 32-year-old single insurance executive, has been a patient of Dr. Paula Nodrama for six years. She was squeezed into an appointment today after calling about a severe upper respiratory infection – a problem she needs to control quickly so that she can attend her best friend's wedding this evening.

It is near the end of the work day, and Bette is the last patient to be seen. Although she is seated in the reception area, Bette notices her doctor standing in the back hallway as she peers through the reception window. Dr. Nodrama can sense Bette observing her as she moves from one exam room to the next. Each time Dr. Nodrama enters the hallway to go to a new room or talk to a nurse, she hears a series of strained and loud coughs coming from the reception area. "What an actress," Dr. Nodrama thinks. "She really wants me to know how sick she feels."

When a nurse brings Bette to an exam room and closes the door, Dr. Nodrama hears no coughing from behind the walls, but when she enters the room, Bette goes on stage, coughing dryly and loudly, again and again.

"Okay, that's enough, Bette!" Dr. Nodrama says, a bit more angrily than she intended. "You don't have to put on a show and force these coughs to let me know how sick you are. I believe you!"

"I am NOT putting this on," Bette protested, coughing again, louder and more strained. "This bug I have is just horrible." Embarrassed, Bette begins to cry.

"I'm sure it is. Okay, let's take care of the problem," Dr. Nodrama says, sighing heavily. "I hear you have an important event to attend."

### DISCUSSION QUESTIONS

1 Assuming that Bette was indeed exaggerating her cough, should Dr. Nodrama have told Bette that she knew this was an act? Why or why not?
2 Could there have been a better way to impart this information? Or would a simple acknowledgement or expression of sympathy for Bette's discomfort have changed her behavior without the doctor having to be as direct?
3 What are some possible reasons for Bette's behavior? In addition to not feeling well, what emotions might she be experiencing?
4 What repercussions can develop when a patient is embarrassed as a result of something a provider does or says?
5 Having already called Bette on her behavior, what could Dr. Nodrama do or say to repair the relationship before the end of the visit?

## Training Tool #22

### CASE STUDY: THE MADDENING PATIENT

In the midst of a visit with Ken Taminant, Dr. Ann Noid walked into the hallway and pulled aside a colleague to recount several upsetting things her patient said:

> "I've been in your waiting room since 2:00 pm. I suppose you think that your time is more valuable than mine."
>
> "Is that your Mercedes in the parking lot?"
>
> "Do I really need the blood work and X-rays you've ordered – or is this just another way for you to make money off of me?"
>
> "Ouch – that hurt! What are you doing? Trying to kill me?"
>
> "Send in the blonde nurse – the one that's really 'hot,' okay?"

"I've just about had it," Dr. Noid told her colleague. "I hate to admit it, but I can't stand the guy. How in the world am I going to provide the care he needs when I feel that way?" Before her colleague could answer, Dr. Noid took a deep breath and went back into the exam room. Ken was sitting on the exam table reading his medical chart that he had taken from the chart compartment on the outer door.

### DISCUSSION QUESTIONS

1. Does it seem that the physician-patient relationship in this case can be salvaged or even improved? If so, how?
2. In what ways, if any, could Dr. Noid's feelings about this patient be likely to affect the quality of care provided to him?
3. If Dr. Noid initially responded to these statements by laughing them off, what should she do differently now that she has reached her boiling point? How can she control her anger?
4. What are the key issues in Dr. Noid's relationship with Ken? How should Dr. Noid address these issues with him: one at a time, in the context of the entire relationship, or both?
5. What are possible reasons for Ken's behavior? What questions might Dr. Noid ask to verify where these behaviors are coming from?
6. How can Dr. Noid "tell off" this patient in a way that allows her to preserve some sort of physician-patient relationship and maintain her professionalism?

## Training Tool #23

### CASE STUDY: THE WORRIED WELL

Ms. Fran Tick, age 61, is back for another appointment today – her fifth visit in six weeks. Complaints have included twinges in her right leg (she suspected a blood clot), a headache (meningitis or a brain tumor), a raw throat and cold (strep, pneumonia – maybe even lung cancer), and forgetfulness (a stroke, perhaps Alzheimer's). On each of her recent visits, Ellie Viate, DO, did not find any signs of major problems – except that Fran was right about the strep that she picked up from her grandson. Today Fran wonders if she is having heart problems, reporting shooting pain in her arm for the last few days.

On each of these previous visits, Dr. Viate has taken Fran's concerns seriously; she examined Fran, and treated her symptoms as best she could. Even so, Fran has made it clear that she hasn't been happy that Dr. Viate has refused her requests for MRIs, CT scans, referrals to various specialists, and prescriptions for certain medications that she saw advertised on television. She expressed concern that some major health problems are not being diagnosed.

Due to Fran's many frequent visits and minor complaints lately, Dr. Viate suspects that she is one of the "worried well," a patient who presents somatic complaints and conditions for a variety of psychosocial reasons. Today, after ruling out a heart problem – after all, it's important to be sure – Dr. Viate plans to do some behavioral counseling with Fran to identify problems that can be treated at home versus those that require an office visit. She hopes that today's discussion will help; if it doesn't, she isn't quite sure what to do next except keep seeing Fran, despite the fact that it takes time from seeing patients that truly need her help. She also wonders if she should agree to some of the expensive tests Fran has requested, both to appease her and avoid a potential lawsuit.

### DISCUSSION QUESTIONS

1 What are possible underlying reasons for Fran's anxiety about her health?
2 What types of questions could Dr. Viate ask to identify Fran's underlying concerns?
3 What should Dr. Viate say to Fran that would be most likely to convince her to make appointments for the right reasons? What types of things should she not say?
4 How does the way this conversation is handled affect the doctor's chances of salvaging or even improving this relationship?
5 Is it reasonable for Dr. Viate to consider ordering unnecessary tests, simply to appease this patient or avoid a lawsuit? Is it a factor if Fran seems litigious?
6 Why should health professionals take the "worried well" seriously?

## Training Tool #24

### CASE STUDY: SOCIAL HOUR

Mrs. Melanie Collie, a 78-year-old widow, is here again this month. She has the usual aches and pains of her advancing age, but you believe that most of her visits are more a result of her social neediness than her medical concerns. You have no doubt that her symptoms are real, but how many times can you give Mrs. Collie the same diagnoses, treatments, and advice?

During your visits with Mrs. Collie, she talks endlessly about the weather, her church, her unresponsive daughter, and the precious few phone calls that she has received from her grandchildren.

> "Did I tell you about our new pastor? I did? Oh, I forgot!"
>
> "This cold weather is terrible. It keeps me locked up indoors."
>
> "Did I tell you my granddaughter got a prize at the science fair? Oh my, I forgot that I told you about that before."
>
> "I must have been a terrible parent. My daughter doesn't care if I'm alive or dead."
>
> "My problem? Ummm, it's my elbow . . . doesn't it look swollen to you?"

You can't help but like Mrs. Collie. She dresses up for each of her visits with you, her silver hair twisted in a neat bun. She is quite complimentary of you and your staff ("You sweet people, you are all so nice to me!") and tells you that she considers you and the nurses as "dear, dear friends."

Mrs. Collie has another appointment today – this time, there's only been a two week interval between visits – and regardless of the validity of today's medical concerns, you believe you need to say something about the frequency and purposes of her visits.

### DISCUSSION QUESTIONS

1. Since Mrs. Collie does have valid but minor medical concerns, how would you address her frequent visits differently than you would a somatic patient?
2. What will your goals be for this patient encounter?
3. What would you say to Mrs. Collie about the frequency and purposes of her visits? What would you be careful not to say?
4. Assuming that you want to know at least some personal details about your patients, to what extent should you talk with Mrs. Collie about topics that are unrelated to her medical concerns? Please explain.

## Training Tool #25

**A physician is convinced to start taking patients' sexual histories**

# A personal matter

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service, intercultural communication

**OBJECTIVES:**

- to address ways to improve both health care and provider-patient relationships through practice in dealing with personal topics;
- to identify strategies for discussing a patient's sexual history.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

In a brief lecture about sexual health, point out that, unfortunately, this topic is normally not discussed in primary care visits unless a problem arises. Ask participants for reasons why many health professionals don't address sexual health issues. (Likely responses include: embarrassment, feeling ill-prepared, believing that the sexual history is not relevant to the chief complaint, and time constraints.)[1]

Give participants a few minutes to read the case study, and then ask the following questions.

**DEBRIEFING:**

1 How should Dr. Thoreau bring up the subject of Ricky's sexual history since it is not related to his presenting complaint?
2 What questions could Dr. Thoreau ask in order to identify Ricky's sexual orientation?
3 Why do you think that some patients are reticent to tell providers about their sexual orientation? What can providers do or say to address those concerns?
4 In this case, Dr. Thoreau's gender is not noted. Would the questioning be different if Dr. Thoreau is a male? A female?
5 How should Dr. Thoreau respond if Ricky says, "It's none of your business"?
6 What words or phrases should be avoided during history-taking?

1 These reasons are cited in: Nusbaum MR, Hamilton CD. The Proactive Sexual History. *Am Fam Physician*. 2002; **66**(9); 1705–22.

7 Should Dr. Thoreau mention that his/her daughter is a huge fan? Why or why not?
8 Should sexual histories be taken on all patients – even those that you are fairly certain are straight and monogamous? Please explain.
9 How can providers avoid being squeamish about asking personal questions?
10 Why do you think that persons of African-American, Hispanic, and Asian descent are less likely to discuss their sex lives with providers?

## Training Tool #25

### CASE STUDY: A PERSONAL MATTER

Ricky Martinez, a 23-year-old performer and singer, is a new patient of Dr. Thoreau. Today Ricky is visiting Dr. Thoreau about a sore throat and hoarseness. Although minor, these conditions are threatening to impede his performance at a major concert venue this weekend.

Because one of Dr. Thoreau's daughters is a major fan of this local entertainer, Ricky Martinez is well known in the Thoreau household. Dr. Thoreau's daughter and her friends have often been heard speculating on whether Ricky is straight or gay – a question that Ricky has not publicly answered.

Normally, Dr. Thoreau does not take sexual histories of patients – there is so little time for add-ons in this busy practice – but having recently returned from a medical convention, Dr. Thoreau reflected on one of the sessions on "The Importance of Proactive Sexual Histories" in which it was suggested that doctors should screen all patients about their respective sexual histories, and not only for patients that the doctor thinks might be gay, lesbian, bisexual, or transgender.

The lecture about sexual histories was so convincing that Dr. Thoreau has decided to conduct sexual histories of all patients from now on. Dr. Thoreau's visit with Ricky is about to begin. While Ricky's quasi-celebrity status may add a wrinkle to this discussion (perhaps increasing Ricky's reluctance to talk about this topic), Dr. Thoreau believes it is important to address this topic with Ricky the same way as with all patients – with utmost sensitivity.

**A patient's questions may seem "stupid" to some – but not to this provider!**

## Training Tool #26

# No stupid questions

**TYPE:** Role play – provider and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to practice responding to questions that seem funny or even absurd to providers;
- to demonstrate that there are "no stupid questions."

**MATERIALS NEEDED:** A copy of role play sheet for all participants

**PROCEDURE:**

Begin this session by pointing out that some patients do not ask questions because they fear appearing "stupid" to their providers. Ask: "What can you do to make patients feel safe in asking you questions – any questions?" (Most participants will suggest telling patients there are no stupid questions. Point out that some communication experts suggest reframing the statement by saying "There are no bad questions" since "bad" is preferable to the word "stupid.")

Although some questions will amuse providers or give them pause, it is nevertheless important to take patients' questions seriously and allow them to save face. Note that this exercise is to give them practice answering obvious, nonsensical, or absurd questions in a professional way so that open, two-way communication will be preserved.

Ask participants to select a partner and take turns asking one another questions from the role play sheet. After each question is asked, the responder should answer in the way that a provider would answer in a real life situation. After each question is answered, questioners should critique how well their partners responded and what they could do to improve.

**DEBRIEFING:**

1 What did you find most difficult about responding to these questions? Please explain.
2 What strategies were most effective in helping patients save face? Which were least effective?
3 How does helping patients save face contribute to the quality of the provider-patient relationship?

4 What nonverbal behaviors should accompany your responses to these questions? Which nonverbal behaviors should you avoid?
5 What are the possible repercussions if a patient feels ridiculed for asking a question like these?

## Training Tool #26

### ROLE PLAY: NO STUPID QUESTIONS

You and your partner will take turns asking one another the following questions. When you are asking the question, you are playing the role of patient; when responding, you are the provider. Please answer the questions as you would in a real life situation, paying careful attention to your verbal as well as nonverbal response. Following each question and answer, the questioner should tell the responder what was good about the response, and what should be improved.

"After I have the rhinoplasty, will my baby get my new nose or my old nose?"
"Will a cell phone give me brain cancer?"
"Can my contact lens get stuck behind my eye?"
"Will sunbathing burn fat?"
"Can I get pregnant from kissing?"
"Is cancer contagious?"
"If I take a pill for a headache or stomachache, how does the medicine know where to go?"
"Could I be going through mental-pause?"
"If I have my baby circumcised, will that make him Jewish?
"Can I get cavities in my dentures?"
"If I take the decongestant you suggested, won't that lead to a crack cocaine habit?"

## Training Tool #27

**A patient begs a CT technologist to give impressions from a test**

# Vague comfort

**TYPE:** Role play – CT technologist and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to show the importance of diplomatic responses to patients making unreasonable requests;
- to understand that what might seem like an unreasonable request may stem from a valid need.

**MATERIALS NEEDED:** Copies of the two roles for each dyad

**PROCEDURE:**

Ask participants to select a partner and distribute the two roles so that one person in the dyad is playing the role of CT technologist and the other is the patient. Give the group a few minutes to read over their respective roles, and note that each pair will have 15 minutes for the role play, followed by an all-group discussion.

**DEBRIEFING:**

1 In your dyad, did the CT technologist tell the patient what she wanted to hear? Why or why not?
2 What are the risks to Connie and the radiologists if Connie mentions that she didn't notice a tumor?
3 Would it matter if there actually is no tumor? Please explain.
4 In your dyad, how did Connie tell Mrs. Break that she wouldn't be able to comply with her wishes? What reasons did she give?
5 What did Connie say to help Mrs. Break calm down and get through the holidays?
6 Based on what happened in your role play, how would Mrs. Break be likely to feel about this diagnostic center at the conclusion of her visit?
7 Is there even a relationship here to protect? That is, does it matter that Mrs. Break has only just met the technician and will never come face-to-face with the doctors reading her scan?

## Training Tool #27

### ROLE PLAY: VAGUE COMFORT
CONFIDENTIAL INSTRUCTIONS

**CT Technologist – Connie Clearview**

It is December 24, the day before Christmas. You can barely wait until tomorrow! Later tonight, you and your spouse will go to the airport to pick up family members that you haven't seen for more than a year. You have planned a wonderful holiday meal.

You thought of these plans as you removed the IV from Mrs. Anita Break, a 61-year-old patient who has just had a chest CT scan, which her doctor ordered due to suspicions of a tumor. While you administered the test, you noticed that this patient was unusually nervous. You tried your best to calm her down, saying every soothing thing that occurred to you. Seeing patients upset is the most disconcerting thing about your job; you can't stand to see people suffer and would do practically anything to ease their minds.

"The test is over now," you said. "You can relax! That's all there is to it." You excused yourself momentarily so that you could go upstairs to look at the images on a computer monitor to see if all required views came out all right. As a certified CT technologist for the past eight years, you can tell when an image is good or not. You aren't qualified to read the scans, of course, as only a radiologist can do that. But having seen as many scans as you have over the years, you were pleased that you didn't see anything that stood out on this patient's CT – at least as far as you can tell. If only you could tell Mrs. Break that her scan looks good to you! But the radiologists have been adamant that you do not discuss anything you see on the scan with any patient. After all, what if you said something that turned out to be in error?

When you came back from checking the scans, you told the patient that you just saw them and they resulted in good, clear images. You told her that her primary care physician would be notified about the results after the radiologist had a chance to review the scan. Because of the Christmas holiday, you noted that it might be after the New Year before the results are available.

Just as you said that, Mrs. Break began shaking uncontrollably and you asked her what was wrong. She is about to tell you. The role play begins as you decide how to respond to the patient's request. You are torn about what to say because you would feel a lot better if you could help Mrs. Break have a worry-free holiday.

## Training Tool #27

### ROLE PLAY: VAGUE COMFORT

CONFIDENTIAL INSTRUCTIONS

**Patient – Anita Break**

As a 61-year-old female, you should be able to handle the shades of grey in life much better than you do, but as you often joke to friends and family, you "simply aren't wrapped too tight." In particular, you are known to come apart at the seams when you are waiting for medical reports. To you, there is no greater agony than not knowing what you are facing. Especially now – the day before Christmas!

You have just had a chest CT scan that your doctor ordered to see whether or not you have a tumor. After the CT technician, Connie Clearview, removed the IV and checked the images for clarity, she told you that because of the holiday season, you might have to wait until after the New Year before you learn the results from this test. That would mean waiting at least a week before you find out whether you have a tumor or not which, for you, would be unbearable!

When Connie mentioned the possible delay, your nerves became even more frazzled and you began to shake uncontrollably. Connie asked you if anything is wrong, and you have decided to make a very heartfelt request:

- Tell Connie that you do not believe you can get through the holidays without knowing the results of your CT scan. A week would be an eternity to you, and your holiday celebrations would be ruined by not knowing.
- If she tells you she's not qualified or permitted to read the results of a CT, tell her you know that she has seen plenty of scan results from her job and that you know she would be able to recognize whether or not there's a problem that you should be concerned about.
- If Connie still resists, tell her it would be the most humane thing she could do to tell you if she *didn't* see a problem. Only then would you be able to enjoy the holidays.
- Still won't tell you? Urge her. Plead with her! Beg! Tell her that you won't let anyone (e.g. the radiologists) know that she told you.
- Still holding back? Tell Connie that you don't care if she is lying to you – but that it would mean the world to you if she'd simply *say* she didn't see any sign of a tumor – even if there is one.

**An elderly patient with dementia yearns to be believed**

## Training Tool #28

# Believe me

**TYPE:** Role play – provider and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Improving patient relationships, customer service

**OBJECTIVES:**

- to identify ways to deal effectively with delusional patients;
- to show the importance of helping patients maintain their dignity.

**MATERIALS NEEDED:** Copies of the two roles for each dyad

**PROCEDURE:**

Beginning with a brief lecture about treating dementia, point out that many patients suffering from delusional disorder discuss their issues with primary care providers rather than psychiatrists or other mental health professionals, usually because they do not believe they have a mental health problem. Ask rhetorically, how do you discuss these patients' concerns when your perception of reality is different from theirs?

Distribute the instructions so that one person in each dyad is the provider and the other is the patient. Give the group 15 minutes to role play this exercise, and follow with an all-group discussion.

**DEBRIEFING:**

1 In the interest of preserving the provider-patient relationship, did those of you playing the role of doctor feel an urge to tell the patient that you believed her? Or did you resist that urge?
2 What was Mrs. Sinnate likely to be thinking and feeling?
3 How straightforward was the doctor in discussing the issue that was most important to Mrs. Sinnate, (i.e. her believability)?
4 When discussing Mrs. Sinnate's concerns, what language was the doctor careful to avoid? What are the pros and cons of saying, "I believe that *you* believe it"?
5 Which of the doctor's communication strategies were most effective?
6 What did you learn from this exercise about communicating with patients with dementia?

## Training Tool #28

### ROLE PLAY: BELIEVE ME
CONFIDENTIAL INSTRUCTIONS

**Patient – Haley Sinnate**

You are Mrs. Haley Sinnate, a 5'3", 240-pound woman who is just about to celebrate her 96th birthday. You have lived alone for 35 years, ever since your husband Harold passed away, and still reside in the same two-story house that you and Harold bought when you got married. You're still able to navigate the stairs to your bedroom on the second floor – albeit a lot slower these days – and steadfastly refuse pleas by your "children" (Gail and Gary, now in their 70s) to move into a long-term care facility.

The last 10 years have been particularly difficult for you. If only you hadn't hired Carl Gardener, the handyman who did work in your yard for more than a decade! You fired Carl more than 20 years ago after you suspected him of stealing Harold's old tools from the garage. Now, each time you walk outside, you see him standing across the street, staring at you as he rattles his keys.

You know that Carl has broken into your home repeatedly. He has stolen your size 5 orthopedic shoes on numerous occasions and your size 2X brown dress suit. (When your 87-year-old brother said he found the shoes and suit in your closet, you pointed out that Carl must have been afraid of being caught and brought them back.) Carl has also stolen your wallet and grocery list and, one night, you saw him putting itching powder in your trash barrel so that he could "get you" when you brought out the garbage. When you were nauseous one night last week, you realized that Carl had poisoned your apple juice.

You've done everything possible to keep Carl out of your house. You have signs on the door warning him that you will contact the authorities, and have spread flour on the floor of your entryway so that you'll have evidence of his footprints. On at least two occasions, you've called the police. You won't do that anymore, no matter what, because on both occasions, they called an ambulance and sent you to the hospital.

It distresses you no end to know that your children and grandchildren, as well as your two surviving brothers and sister, do not believe what you tell them about Carl's break-ins. Neither do the police. Sometimes, your brothers and sisters even yell at you, telling you that you are imagining things. That makes you livid! You know what you see. And there is no way for things missing in your house to walk away by themselves.

You are now seeing your primary care provider about the recurring nausea to see if there is an antidote to the poison that Carl is still putting in your juice. If the doctor suggests some type of psychotropic drug like all the others did, forget it! You will be

especially angry if the doctor says this is all in your head. As you say to everyone who doubts you, "Don't you believe me?" If this doctor doesn't, you'll vow to find one that will.

## Training Tool #28

### ROLE PLAY: BELIEVE ME
CONFIDENTIAL INSTRUCTIONS

**Provider – Rhea Life, MD**

Today you will see Mrs. Haley Sinnate, a 5'3", 240-pound woman who is just about to celebrate her 96th birthday. She has lived alone for 35 years, ever since her husband Harold passed away, and steadfastly refuses pleas by her "children" (Gail and Gary, now in their 70s) to move into a long-term care facility.

The last 10 years have been particularly difficult for Mrs. Sinnate. She believes that a man, Carl Gardener, who did yard work for her several years ago, has been stalking her. When she misplaces things, she believes he has broken in and stolen them; when she feels ill, she believes he is poisoning her. On two occasions when Mrs. Sinnate called the police to report Carl's criminal acts, she was taken by ambulance to the hospital.

Before this visit, you received a call from Mrs. Sinnate's 70-year-old daughter, Gail, who explained that there is no validity to her mother's claims. Her mother hadn't seen Mr. Gardener for more than 20 years – and what would a 6'3" thin, elderly gentleman want with her mother's tattered brown suit (size 2X) and her size 5 orthopedic shoes anyway? Most items her mother has lost have resurfaced, although a few things still missing are probably hidden in a closet or drawer.

Gail told you that she doesn't believe her mother is a danger to herself or others – except that she and other relatives have nearly broken their necks on the flour that her mother has strewn on the entryway floor to obtain evidence of Carl's footprints. Still, she doesn't know what her mother might do next. Family members have lost their patience with her mother, often screaming and telling her that her Carl sightings are all in her head. This makes her mother livid, as she believes that what she thinks and feels are very real.

Based on your previous visits with Mrs. Sinnate and your discussion with Gail, you know that your patient wants nothing more than to be taken seriously and be believed. You know that you will have to expertly address the question that Mrs. Sinnate asks of everyone who doubts her stories: "Don't you believe me?"

# Customer service strategies

## Training Tool #29

**Determining the image of your health care organization that you wish to create**

# Shaping perceptions

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to introduce the topic of customer service in health care settings;
- to understand how people's perceptions regarding quality of service informs their views about quality of care;
- to identify ways to shape patient perceptions by creating more positive first impressions.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Point out that the first moments of each patient visit are vital to the formation of the patient's impressions – not only about their individual interactions, but the practice as a whole. Because these impressions are reshaped with each encounter, it is important to provide quality customer service on a consistent basis, to each patient, on each visit, and by all personnel with whom the patient is in contact. Then lead the group in a discussion of the following questions.

**DEBRIEFING:**

1 With the great demand for health care services and with patients often switching providers due to changes in their insurance, is customer service still important these days? Why or why not?
2 It has been well established that people tend to associate the quality of customer service they receive with quality of care. Why do you believe this is so?
3 For this question, I'll give you two choices, so please pick the one that is closest to your opinion about the matter: How would you want our medical practice to be perceived: as a smoothly running, efficient, no-nonsense business – or as an elegant, full-service health spa that pampers its customers? Please explain.
4 What can we do to create better first impressions for new patients? How can we reinforce the desired impressions for existing patients on return visits?
5 While the way people are treated by personnel is obviously more important than many other factors, what messages do patients receive when they notice problems in areas such as comfort or cleanliness?

**Exploring differences in customer service needs by well and sick patients**

## Training Tool #30

# Customer service needs

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to address the differing customer service needs of well and sick patients;
- to highlight the importance of modifying customer service strategies for each individual.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

After a brief lecture about the importance of customer service in health care, ask the group the following questions:

1 What are some of the customer service expectations of well patients who come to a practice or hospital?
2 How do expectations differ for patients who are sick, fearful, anxious, or in pain?
3 Assuming there are differences, what might we change in our organization to accommodate these varying needs?
4 Why is it important to modify our customer service strategies for each individual patient?

Compare the group's responses for questions 1 and 2, and write ideas suggested for question 3 on a flip chart. You can refer to this list later if there are some ideas worth integrating into your practice.

**DEBRIEFING:**

Point out that the purpose of this discussion was to show that patients who are sick or distressed often have different needs than those of well patients, and that presents special challenges in terms of customer service. Also drive home the lesson that while every health care setting should have general customer service guidelines and standards, it is still necessary to modify those services to meet the needs of each individual.

## Training Tool #31



# In the patient's shoes

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to identify the components of excellent customer service;
- to point out that patients associate quality patient care not only with the treatment by their providers, but by all personnel.

**MATERIALS NEEDED:** Flip chart, several pairs of shoes (a woman's shoes, a man's shoes, orthopedic shoes, a toddler's shoes)

**PROCEDURE:**

Begin by asking participants: "What are 10 customer service 'musts' for any health care organization?" Write the group's responses on the flip chart. If more than 10 are listed, ask the group to prioritize the list to identify the top 10 essentials. Then ask, "Of the items listed, how many do we excel in? Where do we need to improve?"

Next, hold up the first pair of shoes that you have brought to the session. (Visual aids make the session memorable for participants, but if you didn't bring the shoes, ask the group to imagine them.) Say, "These are the shoes of a new patient to our practice. Pretend that you are putting them on, because I will ask you to see our practice from this patient's perspective as you consider what our customer service looks like, sounds like, and feels like."

**DEBRIEFING:**

As you display each pair of shoes, ask the following questions. (You'll need to revise these questions when addressing the perspective of the toddler.)

1. What do you hear when you first call our office? What would you rather hear? What might you hear that would be "turn-offs"? (Compare responses to the list you have written on the flip chart. If personalized attention is listed as one of the 10 customer service essentials, for example, getting a recorded message may be counter to that goal.)
2. What do you see, feel, hear, and smell when you enter the reception area?
3. What do you hear and see upon check-in? What, if any, might this patient perceive as barriers – both physical and personal?

4 You are now being escorted to the exam room. What do you see in the room while you are waiting for the provider to enter? What impressions are created about the practice?
5 While weighing you, and taking your temperature and blood pressure, a nurse is talking with you about the reasons for your visit. What would you see and hear that contributes to a positive impression of your visit? What would cause a negative reaction?
6 Your provider enters the exam room. What would make you feel welcomed and affirmed as a person? What would contribute to the development of trust?
7 What will help to give the impression of quality customer service *during* your exam?
8 What do you hear and see upon check-out? What would make you feel that you are being treated as a person rather than a payee?

Again review the list of 10 customer service essentials. Then ask; "From the perspective of each of these patients, how well do we measure up? What are the differences in customer service needs from one of these patients to another?"

## Training Tool #32

**Designing a clunker, economy, and luxury model of customer service**

# Going the extra mile

**TYPE:** Worksheet

**ESTIMATED TRAINING TIME:** 60 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to understand the different levels of customer service that are possible in a medical practice and to envision what the highest levels of customer service would look and feel like;
- to show that there are many ways to upgrade customer service that are not overly time-consuming or expensive.

**MATERIALS NEEDED:** Flip chart and copies of "The Extra Mile" worksheet for all participants

**PROCEDURE:**

Break into small groups and tell participants to envision the levels of customer service in medical practices in the same terms as they would describe the quality of cars:

- **The clunker.** This is the car that no one wants. In addition to being hail-damaged, the tires are bald, the seats are torn, and it seems to be so temperamental that it only starts on the days it wants to. It seems that the only way to save this car from the scrap heap is to give it a complete engine overhaul.
- **The economy car.** It works fine, and it is quite affordable because it has few if any extra amenities. It does the job, getting you from here to there, but there is little that's special about it.
- **The luxury model.** This plush car has nearly everything a driver could want! It has a sleek style and is known for its stunning performance. It has exceeded all safety crash tests, and it is equipped with anti-lock brakes, a V-8 engine, 7-speed automatic transmission, comfortable heated leather seats.
- **The super-luxury model.** This car has everything the luxury model does, plus a pull-down TV in the back seat, a navigation system with voice recognition, a back-up sensing system, the capability of parking itself, and much more. What's more, it's eco-friendly and gas efficient. It's a dream car!

Distribute the worksheet to participants, pointing out that the "Clunker" and "Economy" sections have already been filled in so that they can concentrate on brainstorming ideas for the "Luxury" and "Super-luxury" categories.

Give the group 40 minutes to fill out their form, and use the remaining time to conduct an all-group discussion.

**DEBRIEFING:**

1 In your "Luxury" and "Super-luxury" categories, what are the best ideas on your group's dream list for top-notch customer service? (Write responses on the flip chart.)
2 If any of the items listed in these categories are not practical in terms of cost or time, what could be done to provide an elevated level of service while reducing the cost or time commitment?
3 Which ideas can be implemented simply by developing a greater customer service mentality?
4 When people are purchasing cars, they look at factors such as safety, quality, comfort, appearance, reliability, and value. To what extent do these factors relate to the service that customers seek in health care settings? Please explain.
5 Which of the four categories best describes the customer service we offer here?
6 How would patient reactions differ by shifting from customer service in low-end to high-end categories? What would be the benefits in terms of employee job satisfaction? To the practice as a whole?

## The Extra Mile

| Customer service need | Clunker model | Economy model | Luxury model | Super-luxury model |
|---|---|---|---|---|
| A patient calls for an appointment. | *The patient listens to a recording, even though the office is open.* | *The receptionist makes the appointment efficiently. Her voice is all business – not exactly welcoming.* | | |
| New patients try to learn about the practice. | *You assume they will learn how the practice runs as they go along.* | *In addition to a stack of fact sheets in the reception area, patients can see the practice's website on the Internet.* | | |
| A patient wishes the time would go by more quickly while waiting to be called from the reception area. | *There are tattered old magazines strewn about the room, reflecting the providers' interest in golf.* | *There is a plentiful supply of current magazines on a variety of topics and aimed at a variety of age groups.* | | |
| You want to create an environment that represents calmness and healing. | *You've added some plastic plants and a fish tank – two fish are belly up.* | *Silk flowers, warm colors, soft music, and healthy fish.* | | |
| A mother in the reception area is concerned with keeping her two children under control and entertained. | *It's up to the mother to bring toys or books for the kids.* | *There's a television in the reception area, showing soap operas.* | | |

| Customer service need | Clunker model | Economy model | Luxury model | Super-luxury model |
|---|---|---|---|---|
| A new patient struggles to remember her patient history and medications when filling out intake forms. | *It's up to the patient to remember these things.* | *When making appointments, patients are reminded to bring a current list of medications and strengths.* | | |
| A business person wishes to do work in the reception area while waiting. | *The patient brought a laptop, but should have charged it; the outlets are all filled.* | *There's an open outlet, but the patient will need to move a chair across the room.* | | |
| You are furnishing an office serving a large proportion of geriatric patients with orthopedic problems. | *Patients can sit in the lovely matching chairs.* | *You've placed two footrests in the reception area along with the lovely matching chairs.* | | |
| You want your women's clinic to be professional, but comfortable and patient friendly. | *Your signage notes that this is a women's clinic. That should be enough.* | *Along with a floral décor, you've added lots of "Mom" magazines, cookbooks, and brochures about STDs.* | | |
| A patient approaches the reception desk to check in. | *The patient knocks on the glass partition, waiting to be acknowledged by an irritated receptionist.* | *The receptionist sees the patient, opens the window, smiles warmly and asks the patient to sign in.* | | |

| Customer service need | Clunker model | Economy model | Luxury model | Super-luxury model |
|---|---|---|---|---|
| You want your patients to be as comfortable as possible while sitting on the exam table while waiting to be seen. | *There are prints of flowers on the wall, so they can look at those. The sterile environment is what patients expect.* | *You've placed a few magazines in the exam room and offer a blanket in case they're cold after putting on their gown.* | | |
| Many of your patients need to lie down on the exam table for tests. | *Patients should be happy enough to see you've changed the paper on the exam table.* | *You offer a soft pillow.* | | |
| A patient is worried about remembering how to take each of his newly prescribed medications. | *You've given oral instructions and will repeat them if necessary. Besides, they can read the bottles.* | *You jot down reminder notes for the patient on a prescription pad.* | | |
| A patient wishes to know the results of a recent lab test as soon as possible. | *You tell the patient to call the nurse for results in a few days.* | *You tell the patient that a postcard with a smiley face will arrive by mail if the tests are okay; otherwise, they'll receive a call.* | | |
| You have decided to refer a patient to another practice for specialized testing. | *You give the patient the name of the provider and tell the patient to make an appointment.* | *You ask if the patient needs help making the appointment.* | | |

| Customer service need | Clunker model | Economy model | Luxury model | Super-luxury model |
|---|---|---|---|---|
| You want to provide good patient education about a particular medical condition and what to do at home. | *Providers will tell patients what they need to know.* | *In addition to discussing treatment plans with patients and answering their questions, patients have access to a display board with an assortment of patient education brochures.* | | |
| Some patients have a lot to carry out with them when they leave. | *They can put their free medication samples in their purse or a carry-all.* | *You give them a brown paper bag or a sack from a pharmaceutical company.* | | |
| As the patient leaves, the check-out clerk makes a follow-up appointment. | *Patients are handed a business card with the date and time of their next appointment.* | *Patients are handed a reminder card, and a receptionist gives a reminder call the day before.* | | |
| It's between patient visits. | *The patient will call when they need us.* | *The practice sends out a quarterly newsletter.* | | |
| You want your practice to do what it can to help the less fortunate. | *There are plenty of social service agencies that do this.* | *Some services are provided pro bono.* | | |

## Training Tool #33

**Using a creative thinking technique to identify new customer service strategies**

# What would Disney do?

**TYPE:** Worksheet

**ESTIMATED TRAINING TIME:** 60 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to apply a creative thinking tool called "The Napoleon Technique" in order to identify new customer service strategies.
- to view customer service solutions from a variety of perspectives.

**MATERIALS NEEDED:** Copies of the "What Would Disney Do?" worksheet for all participants

**PROCEDURE:**

Tell the group that they will use a creative thinking tool known as "The Napoleon Technique" to brainstorm various solutions to customer service challenges in your health care organization. As noted in "101 Creative Problem Solving Techniques" by James M. Higgins,[2] this technique involves pretending that you are someone else – a famous person or someone in a different profession – and trying to solve problems from that person's perspective.

After distributing the worksheet and dividing into small groups, ask participants to spend 40 minutes developing ideas for customer service improvements using the perspective of each profession/industry or famous person listed.

**DEBRIEFING:**

1 What suggestions did you give for each of the categories?
2 Which professions, industries, or famous persons gave you the most intriguing ideas?
3 How did a change of mindset enable you to think of different ways to address various customer service challenges in health care settings?

2 Higgins JM. *101 Creative Problem Solving Techniques: the handbook of new ideas for business.* Winter Park, FL: The New Management Publishing Co.; 1994: p. 91.

## What Would Disney Do?

Consider how famous persons or various types of industries would address each of the customer service challenges listed below that a health care organization might experience. Use at least one of the suggested perspectives for each item to develop your recommendations.

WORKSHEET

| Challenge | Suggested perspectives |
|---|---|
| 1<br>Waiting in the reception area | Disney World<br>Airlines<br>World-class restaurants |
| 2<br>Creating a patient-friendly environment (comfortable, inviting, and professional) | Frank Lloyd Wright (architect)<br>Andy Warhol (artist)<br>Martha Stewart (homemaking expert) |
| 3<br>Ensuring that the practice is welcoming to persons from various cultures served by the practice | EPCOT<br>Top-notch resorts<br>United Nations |
| 4<br>Ensuring that the office is child friendly | Bill Cosby (comic)<br>John Walsh (child safety advocate)<br>Dr. Seuss (author) |
| 5<br>Greeting and checking in patients | Oprah Winfrey (talk-show host)<br>Rachel Ray (cook)<br>Casino executive |
| 6<br>Initiating new patients to the practice or organization | Welcome Wagon volunteers<br>Hotel concierges<br>Singles clubs |
| 7<br>Performing various medical tests and procedures | Research scientist<br>Housekeeper/sanitation engineer<br>Massage therapist |
| 8<br>Maintaining spirits of patients who are seriously ill | Member of the clergy<br>Motivational speaker<br>Politician |

| Challenge | Suggested perspectives |
|---|---|
| 9<br>Negotiating treatment plans with patients | Donald Trump (real estate tycoon)<br>Dr. Phil (TV psychologist)<br>Alan Dershowitz, Esq. (defense attorney) |
| 10<br>Creating a memorable exit | Elvis Presley (singer)<br>Bill Gates (computer magnate, philanthropist)<br>Steven Spielberg (film director) |
| 11<br>Maintaining customer relationships between visits | Airlines<br>Department stores<br>Plush resorts |

**Developing criteria for customer service awards for your practice**

## Training Tool #34

# And the winner is . . .

**TYPE:** Small group discussions

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to raise awareness of the need for excellence in customer service;
- to explain that people are more motivated to act the way you want when they are rewarded for positive behaviors than if they are admonished for negative ones.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Tell participants that, according to behavioral learning theory, people tend to increase behaviors that are rewarded. Alan Garner explains this in his book entitled *Conversationally Speaking*,[3] noting that "people are more likely to continue acting the way you want them to if you reward them for doing so than they are if you punish them for acting differently."

In order to identify the positive behaviors that need to be reinforced, tell participants to spend 15 minutes developing criteria for a new customer service award for personnel in your health care organization. The criteria should be elevating, yet achievable by everyone who is in contact with patients. After the time limit, reconvene participants for an all-group discussion.

**DEBRIEFING:**

1 What criteria did your group suggest? (Write responses on the flip chart and notice which ones were suggested by more than one group.)
2 How can we reward these positive behaviors in ways other than giving an award?
3 How frequently do we give positive strokes to one another for providing excellent service?
4 Since excellent customer service is part of everyone's job, why praise people for doing what they are supposed to do?
5 Should we implement this new customer service award? If we do, what should our

3 Garner A. *Conversationally Speaking: tested new ways to increase your personal and social effectiveness.* 3rd ed. Los Angeles: Lowell House; 1997: p. 18.

process be for selecting each month's winner? What can be done to ensure that the award actually recognizes excellence in customer service and does not become merely a popularity contest?

**Three patients decide to stop seeing their respective providers – do you know why?**

## Training Tools #35–7

# Case studies on patients who leave

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVES:**

- to show that an open provider-patient relationship should have limits in terms of how much personal information to reveal;
- to illustrate the importance of avoiding TMI (too much information) about personal matters in patient care visits.

**MATERIALS NEEDED:** Copies of one of the case studies on the following pages for all participants

**PROCEDURE:**

Break into small groups and distribute one of the following case studies to participants.

- **Small world** – A counseling patient loses faith in her psychologist.
- **Point of no return** – A physician assistant discusses his political beliefs with a patient holding opposite views.
- **The great escape** – A family nurse practitioner tells patients about her dream vacation.

Ask the groups to spend 15 minutes addressing the questions following the selected case study. Then follow with an all-group discussion.

**DEBRIEFING:**

1 Generally speaking, will provider-patient relationships get closer when both parties reveal personal information to one another? Please explain.
2 Since patients are expected to reveal a great deal of personal and sensitive information to their providers, should there be at least some exchange of personal information from provider to patient? If so, what limits should providers consider?
3 What are the lessons from this case about subject matter that is "safe" for discussing with patients? What topics or details may be inappropriate?

## Training Tool #35

### CASE STUDY: SMALL WORLD

Dee Straught, a 46-year-old single woman, has been in counseling with psychologist Greg Arias for two months. During her first visits, Dee described the anxiety and panic attacks she was suffering as a result of relationship problems with her boyfriend, Lou.

As Greg learned, Dee had been seeing Lou for nearly a year. At first, he was quite attentive, calling her every day and sending her flowers for no occasion at all. Dee was on top of the world. She had waited all her life for Mr. Right, and here he was!

A few months ago, Lou's interest in Dee began to wane considerably. The calls decreased to once or twice a week and evening dates to dinner and the movies were cut practically in half. Sure, Dee still saw Lou a few times each month – as long as he wasn't golfing with buddies, out-of-town on business trips, or who-knows-where-else – but the distance between them continued to grow.

"I know he's trying to gently phase me out," Dee cried. "He's planning to see me less and less until I no longer hear from him at all. But I'm telling you, Greg, he's the one for me. Without him, I don't know how I . . ."

Greg felt tremendous compassion as he listened to Dee trying to get the words out between sobs. His goal was to help Dee feel good about herself whether she ended up with Lou or not. But the more he listened to Dee, the more it appeared that Dee had very little chance of reviving this relationship. So he decided to tell Dee something he knew.

"Dee, I probably shouldn't tell you this, but I happen to know Lou's ex-wife. She's a psychologist too, so I've known her for years and years through our local psychology association. She's a great gal! She has told me a lot over the years about her marriage to Lou and why it fell apart. She said he's a very self-centered, selfish person, and that being married to him was a living hell. I would hate to have the same thing happen to you."

Dee looked at the clock and pointed out that she needed to leave for another appointment, even though there was 20 minutes left in their visit. Her anxiety and panic attacks continued for several months after she and Lou stopped seeing one another, but after this visit, she cancelled her next appointment with Greg Arias and never came back.

### DISCUSSION QUESTIONS

1 Why do you think that Dee decided to discontinue her visits with Greg?
2 Was it a good idea for Greg to have mentioned knowing Lou's ex-wife? Should he

have told Dee what the ex-wife said, since he thought the information would help her? Please explain.

3 What might Dee have thought and felt after hearing this information? Since Greg shared information about someone else to Dee, what might she have thought about how well Greg would protect the confidential information she shared with him?

4 How should Greg have handled this situation?

5 What confidentiality/privacy issues are involved in this case?

## Training Tool #36

### CASE STUDY: POINT OF NO RETURN

When Ed Demant, PA, saw his patient for the first time in months, he greeted her warmly. "It's great to see you, Bea! What have you been up to lately?"

"It's great to see you too, Ed," Mrs. Bea Liefer said. "My life has gotten rather exciting. I'm spending all my spare time lately as a volunteer for a political campaign."

"Really? Which one?"

"I'm working for Frank Faction. He believes in everything that I believe, and I think he'll be a wonderful addition to our government."

Ed's face twisted into a grimace. "Oh Bea, I can't believe you said that. His political party is responsible for all the problems our country has experienced. You're on the wrong side, I'm afraid."

"I respectfully disagree," Bea replied, tightening her jaw. "Frank Faction is a brilliant man who has devoted his life to public service. He is the best choice for health care, the environment, the economy – everything."

"You'd better check your facts, Bea," Ed countered. "Faction has voted for tax increases numerous times, and he is responsible for the war we've been fighting overseas."

Bea's eyes narrowed and her voice started to waver. "Perhaps you should check your facts. Frank Faction has been staunchly opposed to the war from the beginning."

For the rest of the visit, as Ed examined Bea for a follow-up on her rheumatoid arthritis, he disagreed with everything Bea said about Frank Faction and his political party. By the time Bea left, Ed felt invigorated by the lively debate, feeling that he was setting the world on the right path, one voter at a time. Bea never came back.

### DISCUSSION QUESTIONS

1 Why do you think Bea left this practice?
2 Since Ed's political beliefs were not related to the care he provided, was Bea being too touchy about their differences? Why or why not? What might Bea have thought or felt?
3 Was it appropriate for Ed to have discussed his opinions with Bea during this visit? Why or why not? Would the discussion have been appropriate if they shared the same political beliefs?
4 Regardless of whether Ed should have engaged in a political discussion in the first place, was there a point at which Ed should have discontinued voicing his views? What would have been his first clue?
5 Was it a factor that Ed enjoyed lively debates while Bea felt uneasy about them?

6 How should Ed have handled Bea's comment that she was working for Frank Faction's political campaign, given his opposing beliefs? Could he have voiced his own opinion in a way that was less offensive to Bea? If so, how?

7 Should political opinions be taboo in discussions with patients? Why or why not? Since many Political Action Committees encourage providers to express their opinions to patients about health care legislation, should providers feel free to express their opinions about matters related to health care? If so, what is the difference between expressing their opinions about health care and other topics such as politics, gun control, religion, or abortion?

## Training Tool #37

### CASE STUDY: THE GREAT ESCAPE

When Samantha Stark first saw her family nurse practitioner, Gladys Mee, on today's visit, she told Gladys how well she looked.

"Thank you, Sam! I probably still have a glow from my recent vacation. It was a dream come true."

"Where did you go?" Sam asked.

"I was in Italy for 10 days. It was fabulous! We went to five cities – Venice, Florence, Siena, Assisi, and capped off the trip in Rome." Gladys smiled brightly, and showed Sam her new gold bracelet. "See this? I got it in Florence. They have the most amazing gold in Italy of anywhere I've seen in the world. It's 18 karat."

"It's beautiful," Sam said.

"Thanks!" Gladys said, helping Sam adjust her legs into the stirrups on the table. "Now just lean back for me, okay? Knees up a bit more. Have you ever been to Venice, Sam?"

"No."

"Well, I highly recommend it! I'll be through in a minute; just relax, okay? The Byzantine architecture along the winding canals was quite magnificent. We had the most wonderful gondola ride."

Gladys handed Sam a towel. "That wasn't so bad, Sam, was it? You can dress now and then I'll come back in and write your prescription."

After a short interlude, Gladys returned, writing a prescription while telling Sam about the wine tasting in Florence and the wondrous experience of seeing the famous frescoed ceiling by Michelangelo at the Sistine Chapel in Rome.

"Okay, now you're all set to go," Gladys said, handing Sam her prescription. "You really should go to Italy if you ever get the chance. It was a dream!"

Sam smiled politely as she left, vowing in her mind never to return. She cried softly as she headed back to her parents' home where she and her eight-year-old daughter had been residing for the last six months, ever since her own home was foreclosed.

### DISCUSSION QUESTIONS

1 Why would Sam have decided to find a new provider after this encounter?
2 Was it appropriate for Gladys to have described her vacation to her patient? Should she have shown her new bracelet? Why or why not?
3 Was there any comment Gladys made that seemed particularly inappropriate? If so, what?

4 Some patients like to hear about others' lives, regardless of their own circumstances. Since Sam was listening and smiling politely, how could Gladys have known about Sam's sensitivities?
5 What considerations should be at the forefront of providers' minds when communicating with each individual patient?

## Training Tool #38

**A patient experiences a series of mishaps in the ER**

# The fall

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships, customer complaints, managing patient expectations

**OBJECTIVES:**

- to demonstrate that pledges for quality customer service are meaningless in the absence of a customer-oriented culture;
- to show that glitches in customer service are fixable with the right strategies.

**MATERIALS NEEDED:** Copies of the case study on the following page for all participants

**PROCEDURE:**

Distribute the case study to all participants. Assemble small groups of five to six persons each and ask them to assess what went wrong in terms of customer service at each point of the visit and what could be done to correct those problems. Then bring participants back together for an all-group discussion.

**DEBRIEFING:**

1. What, if anything, was good about this scenario?
2. Since some patients drive themselves to the ER, what could have been done to help Terry and other patients get easier access to the entrance?
3. What could the receptionist have done to have better attended to Terry's needs? (Expect a long list of responses.)
4. How should the expected wait-time have been addressed?
5. What could the doctor and nurse have done differently?
6. What would have helped Terry exit the ER exam room more comfortably?
7. What should the hospital administrator have done differently?
8. What could the ER have done for damage control when Terry sent in her negative opinions about her visit in the patient satisfaction questionnaire? What message did the hospital send by not responding?

## Training Tool #38

### CASE STUDY: THE FALL

After barely a sip of her morning coffee, Terry Tripper, age 36, slid her feet into a pair of slippers and ran outdoors in the pouring rain to get her newspaper before it was too wet to read. Not realizing that the ground had become slippery, she lost traction and slid from the wet lawn, knee-first into the adjoining driveway. The palms of her hands were bloodied and scraped from catching herself on the cement, but she was more concerned to see a large gash in her right knee, now dripping with blood. As she tried to stand, she felt a wrenching pain in her right ankle.

Practically crawling into her house, Terry thought quickly about the best way to get to the nearest hospital. Should she call an ambulance? That would be silly, she thought. It's only a sprained (perhaps broken) leg and a bloody knee. A neighbor? They must have all left for work, as she didn't see any cars outside other than her own. Should she call her mother? No, she lived too far away. Her ex-husband? Perish the thought! She wrapped a towel around the blood dripping from her right knee, grabbed her purse and keys, got into the car and drove herself to the hospital, only a few miles away.

Terry was not able to find a parking spot close to the emergency room entrance, so she parked some distance away and hobbled to the front door. The waiting area was filled except for one chair immediately across from the front desk. Before taking her seat, she approached the receptionist.

"I have fallen," Terry said, pointing to her bleeding knee. She noticed that she must have dropped her towel somewhere in the parking lot; it was nowhere around.

"Fill this out and give me your insurance card," the receptionist said, not even looking at Terry. When Terry returned the completed forms, the receptionist reached for it, still not making eye contact.

"We'll call you when a room is available," she said.

More than half an hour passed and Terry's name still was not called. Blood from Terry's knee was pooling on the floor.

Terry again approached the receptionist. "Do you know how much longer it will be?"

"No, I don't. I'll call you when we're ready."

"Could I have a towel – or a mop?" Terry asked, pointing to the bloody floor. The receptionist rolled her eyes, got up from her seat, and returned to her desk several minutes later. "Here," she said, handing her a paper towel. Terry got up from her chair and limped back to the desk to retrieve it.

More than two hours since Terry's arrival at the ER, her name was finally called and she was escorted by a nurse down a lengthy, twisting hallway to an exam room.

Terry wondered about the reason for the wait; she could only see one or two other exam rooms that were filled.

A kind young doctor entered the room and noted that Terry had quite a deep cut in her knee. He said she'd need stitches, perhaps 15–20, but the palms of her hands would heal on their own. An X-ray showed that Terry had not broken her leg; it was merely a sprained ankle. "Sometimes sprains like this hurt worse than a break," the doctor said.

A nurse placed bandages over her knee and taped them. "Good job," the doctor said. "Knees can be hard to wrap."

"You're all done," the doctor said. The nurse pointed the way to the exit.

The pain seared in her ankle as Terry walked through the hallway back to the entrance. When she noticed her bandages slipping down to mid-calf, exposing her new stitches, she reached down in a futile effort to move them back up. But instead of returning to the ER for a new dressing, Terry realized that since nearly four hours had passed as a result of the waiting time, stitches, and X-ray, she was more than ready to leave.

Limping out, trying to affix her bandage along the way, Terry noticed an elderly female administrator that she recognized from the hospital's commercials on TV.

"It's a great day, isn't it? We sure needed this rain!" The administrator smiled brightly, whizzing past Terry and not seeming to notice that she was struggling to walk, her bandage was slipping, and she was visibly in pain. Terry recalled the commercial in which this administrator had appeared: "St. Elmo's . . . the hospital with a heart!" Terry thought of the irony of this comment as she made her way home.

A few weeks later, Terry received a form letter from St. Elmo's Hospital, asking her to fill out a questionnaire to provide feedback on her recent experience in the ER. Terry filled it out immediately, giving the hospital the lowest scores in most categories and attaching pages of addenda with numerous suggestions on things the ER might do to improve.

There was no response from the hospital regarding Terry's dismal report.

**An addicted patient demands a refill for a narcotic painkiller**

## Training Tool #39

# Pain in the neck

**TYPE:** Role play – provider and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships, managing patient expectations

**OBJECTIVES:**

- to identify ways to say "no" to a patient without damaging the provider-patient relationship;
- to introduce the concept of "elegant explanations" as a means of educating patients while touching an emotional chord.

**MATERIALS NEEDED:** Flip chart and a copy of the two roles for each dyad

**PROCEDURE:**

Divide the group into pairs and distribute the role-play instructions so that each person in the dyads is playing an opposing role, one as provider and the other as patient. Give them a few minutes to read their respective roles, noting that you will have additional instructions before they begin the exercise.

Tell the group that the person playing the role of provider will need to refuse the patient's request – but that the manner in which this is done may have a bearing on the future of this provider-patient relationship. Also explain a concept known as the "elegant explanation." Rather than only giving medical and scientific reasons for your advice, the elegant explanation is a means of connecting with patients by helping them understand your message on a personal level. Write the following tips on the flip chart.

- **Appeal to their emotions.** Point out that the explanation should be a combination of facts and logic, along with an affective appeal. In other words, speak from the heart as well as your head.
- **Say "because."** For example, "I'm telling you about the dangers of using this medication inappropriately because . . ." Qualifying your statements with "because" will demonstrate your intentions and also show that you are not just pulling information from thin air.
- **Relate to their position.** Demonstrate empathy for what they are thinking and feeling.
- **Use storytelling techniques.** Without mentioning names, tell stories about

your experiences dealing with others who had similar problems. Use examples, metaphors, and similes to make your stories come alive and enable them to visualize outcomes.

- **Personalize the stories.** Relate the stories to them personally. Use their name and correlate your stories to their experiences.
- **Avoid sounding too preachy.** Particularly with obstinate patients who don't see another way out of their problems, your message should come across as helpful and caring, not as a lecture. Try to get them to draw conclusions from your stories so that they can be part of the decision making.

**DEBRIEFING:**

1 How did the provider refuse the patient's request? Was it done in a way that encouraged the patient to stay with the practice and comply with medical advice – or would the patient be likely to seek another provider and ignore the advice?
2 Should the provider consider removing this patient from the practice? Why or why not?
3 Did knowing the concept of an "elegant explanation" help the provider deal more effectively with Anne Gwish? How well did those who played the role of Dr. Carrington handle the various aspects of the elegant explanation:
   - Did the doctor appeal to Anne's emotions? If so, how?
   - Did the doctor say "because" in each instance where this would have helped?
   - Did the doctor relate to the patient's thoughts, feelings, and experiences?
   - How expertly did the doctor use storytelling techniques? Did he/she personalize the stories? If so, how?
   - How effective was the doctor's tone?
4 When you set limits on what you will not do in your patients' best interest, what can you do to ensure that you are not convinced to do otherwise by a desperate and persuasive patient? In other words, how can you maintain your boundaries when pressured?

## Training Tool #39

### ROLE PLAY: PAIN IN THE NECK
CONFIDENTIAL INSTRUCTIONS

**Provider – Dr. Carrington**

You are about to see a patient, Anne Gwish, age 27, who you believe is addicted to a narcotic pain medication you prescribed last year after a car accident that resulted in ongoing soreness in her neck. You began to be concerned about possible abuse of this medication when you noticed Anne's low blood pressure and rapid heart rate, and later when you heard Anne complain about an upset stomach and vertigo. Your suspicions were confirmed when Anne's husband Ed called you privately to let you know that he found dozens of empty bottles of the pain medication – from many different pharmacies – hidden in drawers around the house. He told you about numerous occasions when Anne had disappeared to other rooms in the house (obviously to take the drug) and, moments after coming back, began to shake and appear to be on the verge of passing out. On several occasions, she actually did. As an example, Ed said that she once passed out at a holiday dinner with several family members present. When her head fell into a plate of mashed potatoes, he and their horrified guests shook her until she woke up.

Ed told you that he is worried for his wife's life. What if she gets behind the wheel of a car when she is on this drug – will she have another car accident and not be as lucky as she was before? Ed said that he has repeatedly urged her to stop taking the drug and check into a rehab facility, but his pleas have fallen on deaf ears. Anne tells him that he doesn't understand the intense pain in her neck. She also says that Ed doesn't know what he's talking about because, after all, this is a prescription.

You expect that Anne will ask you for another refill of the pain medication during today's visit. You have refused her request twice before, but now you know that she is finding ways to get the pills from other sources when you have refused her requests. You promised Ed that you would not tell Anne that he called. On this visit, you will try to do a better job of explaining what Anne is doing to herself and motivate her to take your advice seriously. You have found that the inflammation in Anne's neck has gone down dramatically, and you don't see why she needs this or any other drug except perhaps an occasional dose of ibuprofen when she needs it.

You are now entering the exam room, and Anne is seated on the table. You see in her chart that her blood pressure is perilously low.

## Training Tool #39

### ROLE PLAY: PAIN IN THE NECK
CONFIDENTIAL INSTRUCTIONS

**Patient – Anne Gwish**

A nurse has just taken your blood pressure and you are now seated on the exam room table, anxiously awaiting Dr. Carrington's entrance. You wonder if this will be your last visit to Dr. Carrington. Although you survived the terrible car accident that you were in last year, you have suffered greatly from an excruciating pain in your neck. Along with other treatments, Dr. Carrington prescribed a narcotic pain medication and that seemed to have been the only thing that helped. Why, then, doesn't Dr. Carrington see the importance of giving you a refill? On your last two visits, Dr. Carrington has refused your requests. Perhaps this doctor doesn't realize how inventive you can be! You have seen several other providers to get new prescriptions, and even obtained pills through the Internet, the black market, and clinics in other countries. When your usual pharmacy said that your refills were too frequent, you had the prescriptions filled at other pharmacies. It's inconvenient, but you do what you have to do. You're only 27 years old, and you do not plan to live the rest of your life in pain.

For you, this medication has been like a dear, comforting friend. You feel a sense of well-being – especially in the first moments after you take it – almost to the point of euphoria. There's no pain, just a calmness that you find hard to explain. You don't like some of the side effects, such as when your heart races so fast you feel like it's going to explode, or when you experience an upset stomach and vertigo. Nor do you like it when you get so groggy that you can barely relate to anyone. It's also annoying when your husband Ed complains that you are embarrassing him when you pass out after taking the drug. He said you once fell into your mashed potatoes at a holiday dinner in front of your relatives, but you don't even remember that. As if everyone else in the world is perfect!

At today's visit, you will ask – plead – for Dr. Carrington to give you a refill. (The other doctors you've seen have begun to refuse you too, and you are running out of doctors.) You will try to appeal to Dr. Carrington's compassion. Ed doesn't understand the intensity of your neck pain, but if your doctor doesn't care either, maybe it's time to find a new doctor in another community.

While you argue vociferously that your neck pain is your reason for taking the pain pills, the truth is that you haven't felt neck pain for quite a long time. But you can't give up on this painkiller. Not now. Maybe not ever.

Converting the automatic "no" to a deliberate "yes"

## Training Tool #40

# From no to yes

**TYPE:** Role play – positive response and negative response

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer service, improving patient relationships

**OBJECTIVE:**

➥ to practice saying what can be done for a patient or colleague rather than what cannot be done.

**MATERIALS NEEDED:** A copy of the role-play exercise for all participants

**PROCEDURE:**

In a brief lecture, explain that health professionals often wear their "critical thinking hat," hearing an idea or suggestion and immediately assessing what is wrong with it and why it won't work or cannot be done. This results in an "automatic no," which may result in customers feeling that they have not been heard or that their suggestions have not been fully considered.

As you distribute the role-play instruction sheet to all participants and divide the group into dyads, point out that the purpose of this exercise is to practice converting the automatic no to a deliberate yes; in other words, to tell customers what you can do for them rather than what you cannot. Tell them that both persons in each dyad should take turns practicing a positive response. When one person practices their "yes" response, the other should provide a critique. After 15 minutes, bring participants back for an all-group discussion.

**DEBRIEFING:**

1 How many of you found this exercise difficult? If so, what are the reasons?
2 Which situations were the most challenging? Why?
3 How would the patient perceive customer service differently when hearing a positive response rather than a negative one?
4 What did this exercise teach you about being positive and flexible?

## Training Tool #40

### ROLE PLAY EXERCISE: FROM NO TO YES

| Situation | Automatic no<br>What you CAN'T do . . . | Deliberate yes<br>What CAN you do? |
|---|---|---|
| 1<br>You cannot fit a non-emergency patient into today's schedule. | "Sorry, Mrs. Jones. We don't have any openings for today." | |
| 2<br>A patient wants an antibiotic for a common cold. | "No way – antibiotics are not for treating viruses." | |
| 3<br>A patient wants a referral to a gastroenterologist that you believe is unnecessary. | "No – your condition does not warrant a referral." | |
| 4<br>A stressed-out nurse wants two weeks off during your busiest time of year. | "No! We can't be shorthanded at a time like this." | |
| 5<br>A patient wants you to take extra time during today's visit addressing minor last-minute problems. | "Sorry. I only scheduled enough time today for your presenting complaint." | |
| 6<br>A non-patient family member who is accompanying a patient asks you for medical advice for his own problem. | "Sorry. We don't provide advice or services to non-patients." | |

| Situation | Automatic no<br>What you CAN'T do . . . | Deliberate yes<br>What CAN you do? |
|---|---|---|
| 7<br>A patient insists on an MRI to rule out a brain tumor, noting that insurance will pay for it. | "No. There's no reason to order that test." | |
| 8<br>A patient calls the office and demands a house call. | "No, we don't make house calls." | |
| 9<br>A patient asks to pay her outstanding bill over a period of six months at no interest. | "No, we're not a bank. You have to pay in full." | |
| 10<br>The office policy is that each patient is required to make a co-payment on the date of service. | "That's a huge problem that you didn't bring your checkbook. You need to pay *today*. Don't you see the policy on this sign?" | |

# Dealing with customer complaints

## Training Tool #41

**Identifying likely emotions among those who deliver and receive complaints in health care settings**

# Emotional responses to complaints

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Customer complaints, customer service, patient relationships

**OBJECTIVES:**

- to show that complaints often evoke a range of emotional responses for both the complainant and health care professionals who hear the complaints;
- to explain that health care professionals often personalize complaints due to the passion and ownership they have for their work;
- to identify ways of neutralizing emotional responses.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Ask the group to list the emotions they are likely to feel when a patient complains about your health care organization. Jot down responses on the flip chart.

Next, ask the group what emotions patients are likely to feel when they are dissatisfied enough to lodge a complaint. Write these on a separate page.

**DEBRIEFING:**

Looking at the two pages, point out that there is an emotional undertone for all persons involved in a complaint: the person delivering the complaint and the health care professional who receives it. Then discuss the following:

1. What are the similarities and dissimilarities between the two lists? Do you notice that most if not all responses are negative emotions?
2. Why do health care professionals tend to take complaints personally if the complaint is about the practice and not about them personally? (Most will say that this is because health care professionals feel a great sense of pride and ownership in their work.)
3. If both parties maintain their heightened emotions, what is the likelihood of resolving the complaint successfully?
4. What can you do to contain your emotional response when hearing a complaint?
5. How can you best neutralize the emotions of the complainant?

**Identifying and addressing personal and organizational obstacles to effective complaint-handling**

## Training Tool #42

# Addressing customer complaints

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Customer complaints, customer service, improving patient relationships

**OBJECTIVES:**

- to help participants understand that problems with policies and procedures as well as with people can create obstacles to effective complaint-handling;
- to identify remedies for each of these obstacles.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Begin by noting that when health care professionals hear complaints by patients, their first reaction is often to deal with it quickly, brush it off, and remove themselves from the situation as quickly as possible. Then ask, "What are some possible reasons that health care professionals might have an aversion to complaints?" Write the responses on a flip chart under the heading, "Personal Barriers." Responses may include: "I'm too busy"; "I thought the complaint was petty"; "I considered the patient to be unreasonable or too demanding"; and, "I hate conflict."

On a separate flip chart page, write the heading, "Organizational Barriers," and point out that sometimes the barrier can be due to organizational policies, procedures, or systems that make it difficult for the person hearing the complaint to do anything about it. Ask participants to identify some of these barriers and write them on this page. Responses may include: not having a process for dealing with complaints; not being trained in complaint-handling; time constraints; only authorizing certain personnel to deal with complaints; the extra layers of work required to investigate, document and report complaints; etc.

As you review the two lists, point out that virtually all of these behavioral and organizational barriers are fixable.

**DEBRIEFING**

1 Why are complaints essential to our health care organization's success?
2 How can we address our personal barriers to complaint-handling? How can we instill the notion among all personnel that each complaint presents opportunities for

improvement in our health care organization and should therefore be regarded as a *gift*?

3 What improvements can we make in our processes, policies, and procedures to respond to patient complaints more effectively and efficiently?

4 What are we doing now to identify patterns of complaints? What can we do to improve in this area?

5 What communication skills are important in addressing patient complaints? (Responses may include: listening and asking questions to get to the root of the problem; empathizing; apologizing; explaining; taking corrective actions; and providing feedback.) In which of these areas, if any, do we fall short?

6 What should you say to patients when solutions cannot be implemented immediately or in the way they would like?

**A hospital representative exchanges correspondence with a family member**

## Training Tools #43

# An exchange of letters

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer complaints, customer service, improving patient relationships

**OBJECTIVES:**

- to show the need to deal with complaints by providing feedback as well as considering the manner in which you communicate;
- to show that while written responses must be carefully worded for legal reasons, responses that are too vague or formulaic will most likely be interpreted negatively by the complainant.

**MATERIALS NEEDED:** A copy of the case study on the following pages for all participants

**PROCEDURE:**

Distribute the case study to all participants and ask them to form small groups. Announce that the group will have 15 minutes to discuss how the director of nursing handled this complaint by the patient's daughter. Then bring all participants back together for an all-group discussion.

**DEBRIEFING:**

1 Obviously, the director of nursing was being quite guarded about the way she responded in her correspondence to Ms. Tiers. What does it seem that she was careful *not* to say – and why? What do you think are the legal implications of the way she responds on the hospital's behalf?
2 Did Ms. Shield help or hurt the situation by the way she responded to this complaint? Please explain.
3 What could Ms. Shield have said or done differently, while still not admitting guilt?
4 What do you think would be the likely reaction of Ms. Tiers after receiving what seemed to be a "form letter" at the end of their exchanges? What would have been preferable?

## Training Tool #43

### CASE STUDY: AN EXCHANGE OF LETTERS

Dear Ms. Shield:

I am writing to issue a complaint about one of your intensive care unit nurses, Tyson (Ty) Fewn, RN.

During my father's final days, he was in the ICU at the Maury Bund Medical Center for three weeks. Although my father received care from several other nurses during this period, most of his care appeared to be provided by Mr. Fewn.

Although I have no way of assessing the quality of care that Mr. Fewn provided to my father during his stay, I can tell you that he is completely lacking in the skills required for quality of service. With so many nurses known for their kindness and compassion, I do not understand why Mr. Fewn even chose nursing as his career.

Although I have many other examples, allow me to cite three instances in which Mr. Fewn's actions deeply distressed my family:

1 When it was clear that my father had only days if not hours left to live, Mr. Fewn announced that my mother, brother, and I would need to leave my father's bedside because visiting hours were over. I explained to him that my mother had been married to my father for 42 years and begged him to at least let her stay. He pointed toward the door and said, "I'm not telling you again. All of you! Leave!"
2 On another occasion, after the doctors put my father on a respirator, we noticed that he appeared to be in great discomfort. Bubbles of saliva were spurting from his mouth and dripping on his hospital gown. We asked Mr. Fewn, who was standing nearby writing something in a chart, if he would please clean the area around my father's mouth. He threw down his chart violently, grabbed a towel, brusquely wiped off my father's face, and stomped off. Moments later he returned and ordered us to leave again.
3 When we advised Mr. Fewn that my father appeared to be in great pain and that perhaps he could bring in the doctor to adjust his medication, Mr. Fewn said, "I'll be the one who determines when to call the doctor! He's MY patient!" No longer able to tolerate the situation, my normally genteel mother screamed back at him: "Oh yeah? Well he's MY HUSBAND! GET THE DOCTOR! NOW!"

As I said, Ms. Shield, these are only three examples of the many brutal experiences we had with Mr. Fewn. He has virtually no people skills and no compassion. It is hard enough to live through the passing of a loved one without having to be treated like

this. I strongly urge you to take appropriate action against Mr. Fewn so that no other family will have to endure what we did.

Sincerely
Tamara Tiers

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Dear Ms. Tiers:

Thank you for your recent letter about your father's stay in the ICU at Maury Bund Medical Center. I am sorry to hear about the passing of your father, but I'm delighted to know that you were satisfied with the quality of care he received here.

I was surprised that you reported problems about Ty Fewn, RN. He is highly regarded by our doctors and nurses alike as one of our most competent nurses. He is also very well liked. In 2004, he was voted by his colleagues as "Employee of the Year!"

At Maury Bund Medical Center, we are always looking for ways to improve our services and are always glad to hear from our patients and their families. Let us know if there is anything else we can do to assist you, and please continue to regard our facility as your hospital of choice!

Sincerely
Sally Shield, RN, PhD
Director of Nursing

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Dear Ms. Shield:

Thank you for taking the time to respond to my recent letter of complaint about one of your nurses, Ty Fewn, RN. Unfortunately, however, you have missed the point.

I am enclosing another copy of that letter, which I encourage you to read carefully this time. As you will see, I did NOT say that I was satisfied about the quality of care my father received under Mr. Fewn's care; that is something I cannot assess. However I did say that my family and I are EXTREMELY DISSATISFIED about his quality of service, which is woefully lacking.

I again urge you to take action against Mr. Fewn so that no other patient or family will be treated so shabbily – especially at such a difficult time.

Sincerely
Tamara Tiers

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Dear Ms. Tiers:

Thank you for your correspondence about our state-of-the-art intensive care unit. We take all opinions and suggestions quite seriously, and we thank you again so much for writing and sharing your ideas!

Sincerely
Sally Shield, RN, PhD
Director of Nursing

Four case studies on dealing with patients' complaints

## Training Tools #44–7

# Case studies on customer complaints

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 45 minutes (two cases)

**THEMES:** Customer complaints, customer service, improving patient relationships, managing patient expectations

**OBJECTIVES:**

- to demonstrate how complaint-handling processes and strategies can be applied successfully to a variety of situations;
- to determine how to best handle complainants that exhibit difficult behaviors.

**MATERIALS NEEDED:** Copies of two selected case studies from the following pages for all participants

**PROCEDURE:**

After a brief lecture on handling customer complaints, divide participants into small groups and distribute two of the following case studies:

- **Hot shot** – A clinic deals with a disgruntled patient after running out of flu vaccine.
- **Excuse me** – A patient demands a sick note or threatens to leave the practice.
- **Delay in billing** – A patient receives a bill six months after service was delivered.
- **Today's the day** – A patient insists that her appointment is today, not tomorrow.

Ask the groups to spend approximately 15 minutes addressing the questions after each of the two case studies. After 30 minutes, bring participants back together for an all-group discussion.

**DEBRIEFING:**

1 Did you apply the process for complaint handling that we discussed earlier? What seemed to help most?
2 What were the similarities and differences in the issues and solutions for the two cases you reviewed?
3 What are the best ways to appease patients when you are not able to acquiesce to their demands?

## Training Tool #44

### CASE STUDY: HOT SHOT

Having missed 21 days of work this year already, Noah Munity is worried about keeping his job. Any virus or cold that's going around, Noah seems to catch it. The last few times he was sick, he was so concerned about taking more days off that he went to work anyway, despite the sneers and complaints of several coworkers.

When his wife told him about a particularly virulent flu that had been going around lately, Noah agreed to get a flu shot. He tried to be the first one in line for shots at the Mayhem County Public Health Center, but there were dozens of people ahead of him. "Hope this line moves quickly," Noah thought. "I don't want to be late for work."

After nearly two hours in line, he could see the people still ahead of him in line turning around and leaving. "Where are all these people going?" Noah asked the receptionist.

"I'm sorry, sir, we've just run out of our flu vaccine. You'll need to come back in a week or so, or get your shot somewhere else."

Noah's face became flushed with anger and he began to shout. "You must have known your supplies were low," he said. "How dare you make me and all the others stand here in line for all this time! You knew two hours ago that you wouldn't be able to give half of these people their shots. DO YOU REALIZE HOW MUCH WORK I'VE MISSED – FOR NOTHING?"

Several nurses came up front when they heard the shouting. Several patients who were almost out the front door ran back to the desk to witness the commotion.

### DISCUSSION QUESTIONS

1 What did it seem that Noah was mostly upset about – not getting the shot, having to wait, or both? Were there other issues?
2 Although no more vaccine would be available for another week, could the problem with Noah have been avoided?
3 How should the receptionist deal with Noah? What communication strategies should she use?
4 Under what conditions should nurses or administrators step in?
5 How should the public health center deal with the crowd of onlookers?

## Training Tool #45

### CASE STUDY: EXCUSE ME

In the 12 years that Olav Kilter has been a reporter for the *Daily Star*, the largest newspaper in the region, he has always found it easy to get along well with other reporters and editors – until the past six months. That's when Barbara Browbeater was promoted as Olav's supervisor. As Olav told several friends, Barbara gives him unrealistic deadlines, complains that he works too slowly, unfairly criticizes his style of writing, and often stands over his desk to watch him type. Barbara also tells Olav he is spending too much time away from the office doing interviews and field assignments.

"You should do more interviews on the phone and spend more time here in the office writing," she said. "You waste too much time."

Olav admits to himself that he does spend more time out of the office than is actually necessary, but that's to get away from Barbara. Whenever he sees her, he becomes extremely agitated and upset.

On today's appointment with Dr. Lee Gallity, Olav is pleading for a sick note – a condition for absence from work that Barbara requires. "I've got to spend some time away from her," Olav explained. "Being around Barbara is killing me, and I have to think about my future options. Please . . . just say in the note that I have some medical problem that will let me be out of there for a week or two."

"I'm so sorry, Olav. You know I can't do that because you aren't really sick."

"Maybe I should have lied instead of telling you the truth!" Olav said, getting increasingly enraged. "I came to you for help, for heaven's sake. Besides, don't you think that mental health is as important as physical health? Would you rather stick to your guns and not write the note – or lose me as a patient?"

### DISCUSSION QUESTIONS

1 Should Dr. Gallity write the note for his patient, just this once? Why or why not?
2 How can this interaction be altered from a contest of wills to a focus on the issues?
3 How can the doctor help to neutralize the patient's emotions?
4 What should Dr. Gallity say or do to address the patient's concerns?
5 Is there a way to address both the doctor's ethics and the patient's needs?
6 What is the effect, if any, of Olav's ultimatum?

## Training Tool #46

### CASE STUDY: DELAY IN BILLING

Kay Autic, the head of the billing department at Hyperville Medical Center, has just received an angry call from William (Bill) Payer, a patient who received an appendectomy at the medical center more than six months ago. Although Bill received numerous statements from his insurance company and believed that all claims for his hospitalization were settled long ago, he received a new bill from the hospital for radiology services in today's mail.

"I don't believe this," Bill said. "What are you doing sending me another bill more than six months after my surgery? If you'd sent it before the end of the year, my deductible would have been paid and insurance would have covered this. Now it won't, and I'm furious."

When Kay tried to explain that there are many steps before bills are submitted to her department, Bill cut her off mid-sentence. "Who do you think you're talking to, Miss? I'm a well-known business leader in this community, and I know very well that there are ways to streamline processes. It is ridiculous that it took more than six months to send this bill."

Kay put Bill on hold while she took a minute to think about how to handle the situation – and to give Bill a little time to calm down. She knew that the delay could have been due to the new computer software her department has been using for the past four months, as very few people in her department have been able to get the hang of it yet. After a minute or so, Kay got back on the line to talk to Bill.

"I'm back, Mr. Payer. Thank you for your patience. Now let's resume our talk."

### DISCUSSION QUESTIONS

1 What should Kay say to this disgruntled patient? Should she tell him about her suspicions about the reason for the delay in sending the bill? Please explain.
2 Would an apology be in order here? If so, how should she word the apology? If she does apologize, should any other steps precede that? If so, what? Why do you think that experts in customer complaints advise against making apologies too soon in the conversation?
3 Should the way that Kay handles this complaint be affected by (a) Bill's point that his insurance will no longer cover this bill because it was sent after the first of the year; or (b) learning that Bill is a well-known business leader in the community? Please explain your responses.
4 Was it appropriate for Kay to have put Bill on hold for the reasons stated?

## Training Tool #47

### CASE STUDY: TODAY'S THE DAY

Alma Knack, age 69, opened the office door and walked swiftly to the front desk at 8:55 a.m., a little out of breath.

"Whew, I made it!" Alma said to the receptionist, as she entered her name on the sign-in sheet. "With all the rush-hour traffic, I was worried about being on time for my nine o'clock appointment."

"Hi, Mrs. Knack! It's so nice to see you again. But I don't have you down for an appointment today."

"Well, there must be some mistake, dear," Mrs. Knack replied. "I know my appointment is today. I'm supposed to see the doctor at 9:00 a.m."

The receptionist looked into her scheduling book, sliding her index finger down the page.

"I found you in our book, Mrs. Knack. Your appointment is for tomorrow."

"Well, dear, you must have written the date wrong. I specifically asked for an appointment on Monday."

"I'm not the one who scheduled you, Mrs. Knack. But I know that everyone who works at the front desk is very careful to get the appointments down right."

"Well, I don't know who's at fault here," Mrs. Knack said. "I only know it wasn't me. My appointment is for today."

### DISCUSSION QUESTIONS

1 How well is the receptionist handling this situation so far? When did this interaction start to go wrong?
2 What might the receptionist have done differently?
3 If this interaction continues in the same tone, how will it likely end up?
4 What can the receptionist say or do to address Mrs. Knack's needs? What if there's no more room in the provider's schedule for today?
5 How important is it to establish who is right in a situation like this?
6 Should the receptionist have mentioned that she wasn't the one who scheduled Mrs. Knack's appointment? Why or why not? What message did this comment send to the patient?

## Training Tool #48

**A patient who thinks she has lupus demands a referral to a rheumatologist**

# To refer or not to refer

**TYPE:** Role play – two physicians

**ESTIMATED TRAINING TIME:** 60 minutes

**THEMES:** Customer complaints, customer service, improving patient relationships, managing patient expectations

**OBJECTIVES:**

- to show that policies, procedures, and differing opinions and priorities may contribute to patient complaints;
- to practice handling complaints by demanding patients.

**MATERIALS NEEDED:** Copies of the "General Instructions" for all participants, and copies of the two roles on the following pages for each dyad

**PROCEDURE:**

Ask all participants to select a partner. If there are an uneven number of participants, ask the extra person to serve as observer or double up on a role with another person. Distribute the "General Instructions" to everyone, and give one person in each dyad the role of Dr. Hatfield, and the other the role of Dr. McCoy.

After participants have read the general and individual instructions, announce that they will have 30 minutes to act out this exercise.

**DEBRIEFING:**

After the exercise, ask the following questions:

1 Did GoodCare HMO's administration do the right thing by asking Dr. Hatfield to address Mrs. Grumbler's complaint with her physician, Dr. McCoy? Why or why not?
2 Did the discussion result in Mrs. Grumbler being taken seriously? Please explain.
3 In your dyad, did you decide to refer Mrs. Grumbler to the rheumatologist?
4 What other issues were involved in this situation? How did you handle Dr. Hatfield's suggestion to loosen up the number of family physician referrals? What other issues did you address, other than whether or not to refer Mrs.Grumbler?
5 Did it matter that Mrs. Grumbler's husband is on the Board of Directors of GoodCare HMO? Please explain.

6 How should the solution reached by Drs. Hatfield and McCoy be communicated to Mrs. Grumbler? What would be her likely reaction?
7 What did this exercise teach you about how policies/procedures and interpersonal differences can contribute to patient complaints?

## Training Tool #48

### ROLE PLAY: TO REFER OR NOT TO REFER

GENERAL INSTRUCTIONS

GoodCare HMO, which enrolls most of Perfecto Multi-Specialty Physicians' managed care patients, has just received a written complaint that followed dozens of angry phone calls from one of the Perfecto group's patients. Specifically, Mrs. Greta Grumbler is very upset because she wanted to see a rheumatologist and her family physician, Dr. McCoy, will not give her a referral. (There is an out-of-plan option, but Mrs. Grumbler believes that the plan should pay for the visit in full.) Recently, GoodCare HMO's administration contacted Dr. Hatfield (the Director of the Division of Family Medicine at Perfecto) to pass along the news of the complaint so that he/she could discuss the issue with Mrs. Grumbler's personal physician, Dr. McCoy.

Mrs. Grumbler has a history of imagining various types of conditions and problems, and Dr. McCoy has not detected a need to refer her to a rheumatologist. (Dr. McCoy said in private that he would prefer to refer her to a psychiatrist.) Specifically, Mrs. Grumbler thinks she has lupus; however, Dr. McCoy contends that the symptoms she has described do not match such a diagnosis.

Mrs. Grumbler is the wife of Mr. Gary Grumbler, who was named this year to GoodCare HMO's Board of Directors.

It should also be noted that the family medicine division at Perfecto Multi-Specialty Physicians, Inc. has always taken pride in their exceptionally high patient satisfaction rates. The results weren't as good as usual in the latest survey by GoodCare HMO, however, probably because some of the family medicine division's managed care patients have reported a difficult time getting referrals. During the past three months, about six patients (other than Mrs. Grumbler) have reported that they believe they should have been referred to other specialists for various complaints and conditions. The Family Medicine Division at Perfecto considers this number of complaints as unremarkable.

Drs. Hatfield and McCoy have agreed to meet to discuss the referral issue. Because of time constraints, they only have discussed this issue in passing.

## Training Tool #48

### ROLE PLAY: TO REFER OR NOT TO REFER

CONFIDENTIAL INSTRUCTIONS

**Dr. Hatfield, Head of the Family Medicine Division at Perfecto Multi-Specialty Physicians**

You are keenly aware of the six patient complaints about the referral issue during the last three months (which is seven complaints including Mrs. Grumbler). You don't consider this a high number considering the number of patients seen in your Division, but you take every complaint very seriously. You wonder if perhaps the complaining patients simply do not understand the nature of the family medicine specialty.

On the one hand, you have great faith in the family physician you are meeting with today (Dr. McCoy). This physician has been known as one of your Division's best diagnosticians; even internists and pediatricians have asked this physician for assistance with their diagnoses on complicated cases.

One reason you are considering asking the physicians to loosen up on their referrals, however, is because of recent complaints by patients regarding the difficulty in getting referrals. While you realize that family physicians often can treat 85–95% of a patient's problems, your Division's overall referral rate is only about 5–7% and that is mainly to the Division of Cardiology. You have recently spoken to the Head of the Internal Medicine Division, and you were interested to find out that their referral rate is 10–15%.

You are aware that the medical staff, including the physician you are meeting with today, believes that physicians' decisions should prevail. On the whole, however, you think there are many advantages in having your physicians refer to other specialists more frequently. It would certainly reduce some of the complaints by patients about the difficulty in obtaining referrals.

In the back of your mind, you also think it might be a good idea to keep the wife of a GoodCare HMO Board member happy. After all, GoodCare is the biggest plan in town and enrolls most of Perfecto's managed care patients. Another point is that Mrs. Grumbler is very active in civic affairs and is known as a blabbermouth. It also concerns you that you're now engaged in high-level negotiations with GoodCare HMO to increase family physicians' capitation rates. You want to resolve this matter quickly so that it doesn't have a spillover effect on your negotiations.

## Training Tool #48

### ROLE PLAY: TO REFER OR NOT TO REFER
CONFIDENTIAL INSTRUCTIONS

**Dr. McCoy, Family Physician**

You take pride in being a board-certified family physician. Because family physicians are trained to treat between 85–95% of all problems, complaints, and conditions for which a patient sees a physician, you believe that family physicians need to refer to other specialists a very small percentage of the time. You have no problem with referring a patient when their problem is beyond your competence or abilities; however, you do not believe it is appropriate to refer a patient when the need does not present itself.

You have diagnosed several cases of lupus during the 10 years you have been in practice and you are quite certain that this is not Mrs. Grumbler's problem. You take pride in being known as an excellent diagnostician; other physicians – even in other specialties – often consult you on difficult cases.

You believe it would be an enormous mistake to send Mrs. Grumbler to a rheumatologist, not only because she does not present the symptoms, but because the referral would be a personal embarrassment to you. You know all of the rheumatologists in the area, and you believe they would question your credibility by referring a "loony" patient to them just to keep her quiet. You certainly do not believe she should be referred based on her status as the wife of a board member. Besides, if you agreed to refer her this time, you believe she would ask for other types of referrals every time you turned around.

You consider yourself a very reasonable person, but on this issue you believe that your decision as the patient's physician should prevail.

Two role plays on dealing with irate patients

## Training Tools #49–50

# Brief role plays on customer complaints

**TYPE:** Role plays – clinic coordinator and patients

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Customer complaints, customer service, improving patient relationships

**OBJECTIVES:**

- to refine skills in managing patient problems and complaints;
- to show that there are valuable lessons for health care professionals from handling any customer grievance.

**MATERIALS NEEDED:** Copies of the two roles of the selected case for each dyad

**PROCEDURE:**

Ask each participant to select a partner. Distribute the confidential instructions for your selected role play so that persons in each dyad are playing the opposing character. Your choices are:

- **The extended visit** – An irate patient calls about being charged for an extended visit.
- **The waiting game** – A patient is upset about a long wait in a medical office.

Announce that each dyad will have 10 minutes to complete the role play, and that each character should try to play his/her role as close to reality as possible. Point out that the clinic coordinator in both of these cases could also be the office manager, medical director, administrator, or another authority figure.

**DEBRIEFING:**

Before the all-group discussion, ask each dyad to meet again privately to talk about what was positive about their roleplay and what might have been handled differently in order to achieve a better outcome. Ask the person playing the role of patient to describe how they perceived the leader's reaction.

To facilitate the discussion about the roleplays, ask participants to describe strategies that seemed to work well, as well as strategies that did not produce the desired results. During this discussion, point out that:

- distressed patients want to feel that the leader is listening and making a genuine attempt to understand their feelings and concerns;
- while reasoned explanations are often necessary, defensive responses will normally cause the discussion to become more polarized;
- patients want to know that their problem will be addressed so they won't be faced with the same concerns on subsequent visits;
- you might want to dismiss the concerns of disgruntled patients because of the manner in which their messages are delivered – but there are valuable lessons for the practice in each of these interactions.

## Training Tool #49

### ROLE PLAY: THE EXTENDED VISIT

CONFIDENTIAL INSTRUCTIONS

**Mrs. Yappington**

You are a patient at a rural health clinic, and you are very upset. You asked to speak to "someone in charge" so that you can describe the billing errors on your last statement. In particular, you think it's wrong that you've been charged for an extended visit when the doctor only spent about 15 minutes with you! You're also concerned about a notice you just received from your preferred provider organization saying that several parts of your office visit are not covered and will not be reimbursed. You are on a fixed income so every dollar counts. You're about to give "these people" a piece of your mind!

## Training Tool #49

### ROLE PLAY: THE EXTENDED VISIT

CONFIDENTIAL INSTRUCTIONS

**Clinic Coordinator**

The receptionist just asked you to handle an irate patient, Mrs. Yappington, who is upset about a recent bill. You are well aware of Mrs. Yappington; she is a chronically disgruntled patient. You would like to address Mrs. Yappington's immediate concerns, but you would also like to establish a better relationship with her so that she is not so distrustful of physicians, nurses, and staff.

## Training Tool #50

### ROLE PLAY: THE WAITING GAME
CONFIDENTIAL INSTRUCTIONS

**Ms. Urie, Patient**

You are now meeting with the clinic coordinator to complain about the way you have been treated by staff during a recent visit. On that visit, you asked a staff person how long it would be before the doctor could see you. You had been waiting for nearly an hour. You felt that the staff person was snippy and unhelpful, continually putting you off, and acting as if you were bothering her. You remember that it was a female, but don't know her name and can't remember what she looked like. You're angry, and it's hard for you to control your temper. You are well known in the community, and you don't believe people should be treating you like this.

This isn't the first time you've been upset with the way you've been treated. Although you've been coming to this clinic for less than one year, you have complained about not getting timely call-backs from the doctor, not having your favorite nurse give you injections, and being "too cold in the exam room" when you're undressed and covered by a sheet.

## Training Tool #50

### ROLE PLAY: THE WAITING GAME

CONFIDENTIAL INSTRUCTIONS

**Clinic Coordinator**

Naturally, you are concerned when any patient perceives that they haven't received good customer service. You're about to meet Ms. Urie, a patient who complained about a long wait on a recent visit. Before meeting with her, you tried to find out who had been dealing with her, but there was a shift change during the time Ms. Urie, was waiting in the reception area so it will be hard to identify the responsible staff person. (Several other persons were helping out in the front office during that time too.)

You have compassion for the staff members who have had to deal with Ms. Urie. Although she is a relatively new patient, less than one year, she complains frequently. (Recent complaints included not getting timely call-backs from the doctor, not having her favorite nurse give her immunizations, and being "too cold in the exam room with nothing to cover me but a piece of cloth.")

Ms. Urie is well known in the community, and you are concerned about what she might say to others. It's now time to meet with Ms. Urie. You are not looking forward to your discussion with her, as she seems to be quite hostile.

**A managed care organization receives a complaint about quality of service**

## Training Tool #51

# Service with a smile

**TYPE:** Role play – physician and managed care representative

**ESTIMATED TRAINING TIME:** 45 minutes

**THEMES:** Customer complaints, customer service, improving patient relationships

**OBJECTIVES:**

- to gain practice in addressing complaints between a provider and a managed care organization (MCO);
- to identify ways to resolve issues when both parties have different sets of complaints.

**MATERIALS NEEDED:** A copy of the "General Instructions" for all participants, and a copy of the two roles for each dyad

**PROCEDURE:**

Ask each participant to select a partner. After distributing the "General Instructions" to everyone, distribute the roles of the physician and MCO representative so that persons in each dyad are playing an opposing role. Announce that the group will have 25 minutes to role play this exercise; the remaining time will be used for an all-group discussion.

**DEBRIEFING:**

1 In this case, who is actually the "customer" – Dr. Fedup, the patients, or both?
2 Given that both characters have complaints about one another, how does this add to the complexity of the problem?
3 What were the issues for each player?
4 Did both parties strive to meet their own needs only – or the needs of the other party as well?
5 What were the obstacles to resolving these complaints? How were the obstacles overcome?
6 What solutions did your dyad identify? Were the solutions satisfactory to both parties?

## Training Tool #51

### ROLE PLAY: SERVICE WITH A SMILE

GENERAL INSTRUCTIONS

GoodCare HMO recently reported the results of a member satisfaction survey. One of the findings involved problems reported by some of Dr. I.M. Fedup's HMO patients regarding quality of service during the past year. Dr. Fedup is a 53-year-old physician with an excellent reputation who was in the top 5% of his/her class at one of the best medical schools in the country. Dr. Fedup has been affiliated with GoodCare HMO for two years.

Dr. Fedup is aware of some complaints by a portion of his/her patients who are GoodCare HMO members, but has not yet heard the specific survey results. Dr. Fedup has tried to ameliorate each complaint that has arisen, but has made it known that many of his complaints are a "direct or indirect result of GoodCare HMO policies and operations."

At a recent quality of care conference, Dr. Fedup had a discussion with Hannah Helpya, a member of GoodCare HMOs Provider Relation's team. While Dr. Fedup related some of his/her concerns, there was not enough time for a full discussion. Hannah called Dr. Fedup soon after the conference and set up a meeting to sort things out. That meeting is today.

## Training Tool #51

### ROLE PLAY: SERVICE WITH A SMILE
CONFIDENTIAL INSTRUCTIONS

**Dr. I.M. Fedup, Physician**

You are Dr. I.M. Fedup and you've had it "up to here." You don't like the entire notion of managed health care, but you begrudgingly became involved in order to maintain your patient volume. Since you affiliated with GoodCare HMO two years ago, you've had one problem after another. You're wondering if your affiliation is worth it, but you do realize that you'd lose a substantial number of patients (and income) if you decided to scrub the whole relationship.

You believe that GoodCare HMO is lucky to have you as one of its physicians but does not appreciate your talents. You have excellent credentials, and believe you are an excellent diagnostician. You are widely published and well-known throughout the region.

A handful of your patients have complained to you, but you have worked hard to handle each complaint and believe that you handled each one very well. Not one of those four or five patients has complained to you again (but not all of them have been back for another visit yet).

If any of the complaints are justified, which you do not believe anyway, then it's because of Goodcare HMO policies and operations. You feel that the paperwork has been abominable; a major stress to you and your staff. You are very upset about the late payments you've been receiving. You've had arguments – even shouting matches – with some of the plan's case managers. And when you complain to management, they either don't call you back right away or they don't act quickly enough. So if you're a little short with some of your GoodCare HMO patients, it's only because the plan has brought this all on itself in the first place. You're a reasonable person, but you think you've been pushed too far.

You have only had a few encounters with Hannah Helpya, who is the GoodCare HMO representative you're meeting with today. You dealt with another of the plan's representatives in previous months, but that person was not particularly helpful.

## Training Tool #51

### ROLE PLAY: SERVICE WITH A SMILE
CONFIDENTIAL INSTRUCTIONS

**Hannah Helpya, Provider Relations Representative of GoodCare HMO**

You are the GoodCare HMO representative who is responsible for dealing with Dr. Fedup. When you looked over the results of the survey, you noticed the following:

- The problems that were reported regarding Dr. Fedup's quality of service involved a significant proportion of Dr. Fedup's HMO patients. Overall, these patients believe they are treated discourteously, especially when compared to Dr. Fedup's indemnity patients.
- There were more written complaints about Dr. Fedup on the survey than there were about most of the plan's other physicians. Typical member complaints were that: Dr. Fedup keeps them waiting for long periods; rushes them out of the examining room; does not take time to explain problems, conditions or treatments; and has a "personality problem." In regard to the latter, it was noted on the survey that "Dr. Fedup is short-tempered"; "doesn't seem to care about me"; "is rude"; and "has the bedside manner of a Rottweiler."
- Some patients reported that Dr. Fedup had badmouthed GoodCare HMO to them about administrative hassles; for example, late payment, paperwork, disputes with case managers, etc.

To date, no one has shared these specific findings with Dr. Fedup. You would like to work things out with Dr. Fedup because he/she is an excellent diagnostician, has excellent credentials, a superb reputation, and is widely published. Obviously, you would like Dr. Fedup to start being more of a team player, and to demonstrate a greater sense of allegiance to the plan. You recognize that there have been some problems with Dr. Fedup's paperwork, and that GoodCare HMO representatives should have addressed some of his/her requests and complaints more quickly. In the past, however, another plan representative had been assigned to Dr. Fedup and admitted to sometimes procrastinating on follow-up because "Dr. Fedup is such a pain in the butt." You have only been assigned to Dr. Fedup for a few months now, and your encounters with him/her have been very minimal to date.

# Managing patient expectations

## Training Tool #52

**Exploring the benefits of identifying patients' expectations and underlying needs**

# About patient expectations

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVES:**

- to explore the benefits of identifying patient expectations;
- to understand what shapes patient expectations and how to respond.

**MATERIALS NEEDED:** None

**PROCEDURE:**

To introduce the topic of "Managing Patient Expectations," ask the group to address as many of the following questions as time allows:

1. What are the benefits of meeting patient expectations?
2. How can health care professionals better understand patient perspectives, both generally and individually?
3. Why are most patient expectations easily satisfied?
4. What shapes patient expectations?
5. Although not often discussed, what do health care professionals expect of their patients?
6. Why do patients sometimes make unreasonable or inappropriate requests?
7. What is the difference between a request and a demand?
8. Should you respond to requests and demands differently? If so, how?
9. What communication strategies help in dealing with inappropriate patient expectations?
10. What types of communication should you avoid?

## Training Tool #53

# Great expectations

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVE:**

- to identify ways to manage patient expectations, usually by lowering or reshaping them.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Tell participants that when patient expectations are unrealistic, health professionals may wish to engage in expectation management: helping patients rethink and adjust their expectations so that they can avoid unnecessary disappointments and frustrations. Tell the group that you will give them a few situations and ask for a discussion on what they would do to manage each one:

- a patient expects you to cure her fibromyalgia;
- a patient expects to talk with you during off-hours – not your partner who is on call;
- a patient expects you to tell her what you found in a recent examination of her 20-year-old daughter.

**DEBRIEFING**

1 When patients voice an unreasonable expectation, what can you say to help them adjust their thinking?
2 What types of things should you *not* say – especially when patients feel justified in expecting what they do?
3 How can you give patients a more realistic picture of what they can or should expect?
4 When the patient has unrealistic expectations regarding cures or length of treatment time, how can you manage their expectations without diminishing their hopes for recovery or quicker improvements?

## Training Tools #54–7

**A selection of case studies on identifying and dealing with patient expectations**

# Case studies on patient expectations

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVES:**

- to identify patients' stated as well as underlying expectations;
- to explore ways to either meet patient expectations or manage their expectations through education and discussion.

**MATERIALS NEEDED:** A copy of the selected case study for all participants

**PROCEDURE:**

Divide participants into subgroups of four to five persons each, and give them a few minutes to read the selected case. Note that each group will have 15 minutes to discuss the case and develop recommendations. Questions are provided at the end of each section, but discussions can take any direction the group sees fit. Your choices are:

- **See me now** – A patient with a severe headache arrives early and wants to be seen sooner than the appointment time.
- **Living in fear** – A fearful patient requests a smallpox vaccine, post 9/11.
- **Quick fix** – A patient wants a prescription she has seen on television.
- **Request for referral** – A patient asks for a referral to a dermatologist for psoriasis.

**DEBRIEFING:**

Ask a representative from each group to report on their recommendations. Then ask the following questions:

1. In these cases, what shades of grey exist in determining whether the patients' requests are reasonable or unreasonable?
2. How can clinicians reconcile their desire to please the patient and do what they think is in the patient's best interest?
3. How can providers deal with patients' unreasonable or inappropriate requests in ways that do not contribute to a power struggle?
4. When there is a gap in expectations, how do emotional undercurrents affect clinician-patient interactions?

5 When the patient makes a specific request and you prefer another course of action, under what conditions would you accede to the patient's demands?
6 How should providers acknowledge patients who suggest good medical options?
7 Recognizing that some strategies are easier to say than do, would you follow your group's recommendations for dealing with these cases in real life?

## Training Tool #54

### CASE STUDY: SEE ME NOW

Mr. Don Fielding, a 32-year-old attorney suffering from persistent headaches, arrives at the office of Dr. Henry Stone at 8:30 a.m. even though his appointment isn't for another hour. Noting his busy day, Mr. Fielding pleads with the receptionist, Christy Sullivan, to allow him to see the doctor earlier. Smiling sweetly, she promises to do everything she can. At 10:00 a.m., Mr. Fielding is still waiting and increasingly anxious. Ms. Sullivan can hear him complaining to other patients in the reception area. "I've been waiting here for an hour and a half," he laments, not bothering to point out that he arrived an hour early. "After all the money I've paid to this practice, I deserve better than this."

Ms. Sullivan consults with the office manager, only to learn that Dr. Stone is behind schedule (he arrived late from nursing home rounds) and won't be able to see Mr. Fielding for at least 30 more minutes. Schedules of other doctors are completely booked.

### DISCUSSION QUESTIONS

1 What was reasonable or unreasonable about Mr. Fielding's expectations?
2 What physical and emotional factors affect his expectations and behavior?
3 What could Ms. Sullivan have done to manage his expectations earlier?
4 What should she and/or the office manager do now?

## Training Tool #55

### CASE STUDY: LIVING IN FEAR

Mr. Barney Pfieffer, a 64-year-old patient of Dr. Andrea Griffin, takes great pride in being up to date on world news. Since September 11, 2001, Mr. Pfieffer has been particularly nervous. He has called Dr. Griffin's office on numerous occasions to request tests for anthrax poisoning and for information on protecting himself from nerve gases. On a follow-up visit related to Mr. Pfieffer's diabetes, Dr. Griffin is not surprised that he is now requesting the smallpox vaccine. When Dr. Griffin explains that the vaccine is not yet available to the general public, Mr. Pfieffer looks at her suspiciously. "How could you not take my concerns seriously, with all that's going on in the world? I know the vaccine is out there; they're allowing you health care professionals to be immunized. Why can't I be protected too?"

Dr. Griffin does not tell Mr. Pfieffer that she is participating in a pilot program to immunize health care professionals and law enforcement officials in her area and therefore has several hundred dosages of the smallpox vaccine in her office.

### DISCUSSION QUESTIONS

1 How should Dr. Griffin address this request with Mr. Pfieffer?
2 What communication strategies should she use?
3 While addressing his concerns from a medical and emotional standpoint, how can she avoid being led into a political or ethical discussion?

## Training Tool #56

### CASE STUDY: QUICK FIX

On her visit with Dr. Ward Hatchet, Mrs. Edie Rascal insists on a prescription for the pink pill she has seen on television. "On the commercial, they listed the symptoms and I have every one of them. Besides, one of my favorite actors was in that ad. I know he wouldn't put his name on a product unless it really worked." While acknowledging that the pill Mrs. Rascal has requested is a possibility for treating her heartburn, Dr. Hatchet explains that he has another medication in mind that he thinks would work better in light of her other symptoms. Looking dismayed, Mrs. Rascal asks, "Are you saying you won't give me the pink pill?"

### DISCUSSION QUESTIONS

1 Since Dr. Hatchet doesn't dismiss the idea of the pink pill, but has another preference, should he continue explaining his reasoning for another medication or give Mrs. Rascal what she wants?
2 What considerations should affect his decision?
3 How can he discourage inappropriate requests from Mrs. Rascal in the future?
4 What should he say, if anything, about the relationship between patient expectations and direct-to-consumer advertising?

## Training Tool #57

### CASE STUDY: REQUEST FOR REFERRAL

Ms. Phoebe Buffet, a 25-year-old massage therapist, has been a patient of Dr. Rachel Greene, a family physician, for one year. Dr. Greene has used a graduated approach to deal with Ms. Buffet's psoriasis, starting with topical treatments and phototherapy with plans for more aggressive, systemic treatments if her condition doesn't improve. After hinting that she is not satisfied with her progress, Ms. Buffet finally musters up the courage to ask Dr. Greene for a referral to a dermatologist. Since she has not yet tried other treatments, Dr. Greene believes that a referral is unwarranted at this point. Although Ms. Buffet's managed care plan requires a referral for subspecialty care, Dr. Greene does not wish to make this referral, but she's torn, not wanting to lose Ms. Buffet as a patient.

### DISCUSSION QUESTIONS

1 What physical, social, and emotional factors could be shaping Ms. Buffet's expectations?
2 How should Dr. Greene convey that a referral isn't necessary at the present time without appearing to dismiss Ms. Buffet's request?
3 Or, should Dr. Greene make the referral to appease her patient?

## Training Tool #58

**A family thinks a crisis is over and assumes they can take the patient home**

# Ready, set, go

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVES:**

- to show how patient expectations can be affected by unclear or incomplete communication with providers and staff members;
- to identify the benefits of modifying patient expectations by acknowledging the problem and having clarifying conversations.

**MATERIALS NEEDED:** A copy of the case study for all participants

**PROCEDURE:**

Distribute a copy of the case study to everyone, give the group a few minutes to read it, and facilitate an all-group discussion.

**DEBRIEFING:**

1. Should the Fide family have known that Terry was continuing to be monitored? How might they have known?
2. How did the expectations of the Fide family change during their visit to the emergency room?
3. How did the behaviors of the physician and nurses affect this change in expectations?
4. What could the physician, nurses, or both have done differently to have avoided this misunderstanding?
5. What should the doctor say to the family to clear the air?

## Training Tool #58

### CASE STUDY: READY, SET, GO

Right after dinner, Terry Fide, age 58, clutched his chest and told his wife Bonnie that he thought he was having a heart attack. Bonnie wasted no time getting Terry and their 16-year-old daughter Petra into the car, and raced to the nearest hospital.

Although the ER was quite busy, Terry was placed into a room immediately and introduced to Dr. Chekit and the nurses who would be taking care of him. After taking Terry's medical history, the team checked his vital signs, including pulse rate, blood pressure, breathing rate, temperature, and auscultation. All preliminary tests were normal, and Terry noted that his chest pain had diminished.

"I'll be back in a while," Dr. Chekit said, "so just stay put."

The nurses also left the room, going outside to hear orders from Dr. Chekit. Bonnie held Terry's hand while he was still lying on the exam table, and Petra began to cry.

"Dad, this is scaring me so much. I don't know what I'd do if anything happened to you."

"I'll be fine," Terry replied. "I'm feeling much better already. I bet they'll let us go home pretty soon."

Two or three times during the next hour, one of the nurses looked into the room, scanned various instruments, and left. Another hour passed, then another.

"I think they forgot you were here," Bonnie said. "Obviously, they know you're fine or the doctor would be checking on you. I'll go find someone and see if they're finished with you now. I'm getting antsy, just sitting here with nothing being done and no one telling us what's going on."

Bonnie went to the large circular desk in the middle of the room and asked a nurse if it was all right for Terry to leave since they had been in the room, most of the time alone, for quite some time.

"I'll ask Dr. Chekit," a nurse said. "It may be a few minutes, ma'am. He's with another patient."

"Tell him we're going to get Terry dressed now," Bonnie said. "We might as well leave; Terry feels better and there doesn't seem to be a reason to sit around here."

When the nurse saw that Dr. Chekit was in a conference room writing notes in a chart, she asked to speak to him.

"Doctor, Mr. Fide's wife just said that she's getting him dressed. She says that nothing is being done so he must be fine. She thinks they should leave."

"THAT INFURIATES ME!" said Dr. Chekit, almost in a shout. "So she is bored and wants to go home? Tell that woman that this isn't about her and her comfort – IT'S ABOUT THE PATIENT! Tell her no, I'm not releasing Mr. Fide until we've completed our monitoring and we're absolutely certain he's not at risk."

Petra had wandered outside of the exam room moments earlier and couldn't help

but hear this entire conversation through the conference room door. She went back to Terry's room and found that her father was already dressed.

"Mom, it sounds like the doctor is pretty mad at you."

"You're kidding!" Bonnie said. "Whatever for?"

"He thinks you want Dad to go home just because you're tired of sitting here, and that you don't seem to care whether Dad is well or not. He told a nurse that they were still monitoring him."

"They are still monitoring him? How was I supposed to know? No one has spoken to us for hours. They just left us in that little room. I think I'll have a word with the doctor."

Just as she spoke, Dr. Chekit entered the room for a chat with the family.

**A physician and family have differing expectations for a terminally ill patient**

## Training Tool #59

# A long explanation

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVES:**

- to show the importance of identifying people's underlying questions or issues before providing lengthy explanations;
- to show that the successful management of patients' and family members' expectations requires two-way communication.

**MATERIALS NEEDED:** A copy of the case study for all participants

**PROCEDURE:**

Distribute the case study to all participants. After giving them a few minutes of reading time, lead a discussion with the following questions.

**DEBRIEFING:**

1. Why do you think that distressed patients or family members often don't get the words out exactly as they had intended?
2. When Emma told Dr. Able that her family "got it" (i.e. what palliative care entailed), what was her underlying message?
3. What could Dr. Able have done to have avoided this misunderstanding?
4. Do you feel that Dr. Able focused too much on the special features of the palliative care unit? Would it have helped if Dr. Able had described the differences between palliative care and hospice care – even if she didn't know that Emma confused these terms?
5. If Dr. Able had identified Emma's misunderstanding of palliative care and/or her inability to accept her brother's prognosis, how would that have helped her manage Emma's expectations as a family member?
6. While Dr. Able's reaction to leave the room after becoming upset was a normal human response, what could she have done to have calmed her own emotions so that she would stay and question Emma further about the reasons for her concerns?

## Training Tool #59

### CASE STUDY: A LONG EXPLANATION

Emma Evergreen picked up the ringing phone at her brother's bedside.

"Yes, this is room 312 at State University Med Center," Emma said. "Yes, it's Steve Evergreen's room. This is his sister, Emma. Can I help you?"

The phone had been ringing off the hook for weeks, and the stream of visitors was constant. When it wasn't an aunt, uncle, or one of their dozens of cousins, scores of Steve's friends would call or visit to convey their concern and best wishes. Each time Emma heard the words, "If there's anything I can do . . ." she always answered the same way. "Yes, there is one thing. You can pray for Steve. Please, please pray."

Steve was diagnosed with pancreatic cancer only five months before. The tumor was too large to be removed surgically, and the chemotherapy had been discontinued when it appeared that it wasn't having any effect. So each day, Emma, her mother, and Steve's wife sat in room 312, each in a separate guest chair. The small room seemed quite crowded when friends and relatives came by. At times, the crowd grew so large that people took turns standing in the hallway.

Emma had a very difficult time accepting the doctor's prognosis of her 48-year-old brother's condition. There had to be something that the doctors could do, she thought. After all, this was one of the best tertiary care teaching hospitals in the region! Surely there was a doctor here with special knowledge that could turn this nightmare around. Maybe there was an experimental drug that they hadn't yet considered?

Steve's oncologist, Dr. Amy Able, came into the room to see Steve, and immediately told Emma, her mother, and sister-in-law that she had some good news: a room had opened up in the palliative care unit! Steve could move into the new room later that day.

Emma figured that she knew what palliative care meant. It was the end of the line. It was where Steve would go to die. It would mean that all of the oncologists had given up hope for Steve entirely. She wanted them to put Steve back on chemo, and now . . .

"That's not what I had in mind," Emma said. "I don't want Steve to have palliative care . . . I . . ." Emma pulled out a tissue and dried her eyes.

Seeing this as a teachable moment, Dr. Able was pleased to tell Emma and her family all about palliative care and the plush new unit the medical center had recently opened.

"Oh Emma, our palliative care unit is wonderful. The rooms are so much bigger, which would accommodate all of the friends and family members who come to visit. Down the hall from Steve's room, we even have a large modern kitchen so that you can have meals and snacks here! And the décor in our new unit is very homelike and beautiful."

"But I don't want him to have palliative care . . ." Emma said, choking back tears. Her mother and sister-in-law remained silent. They knew what was on Emma's mind.

"Let me explain palliative care, Emma. We have a palliative care team that will do everything they can to make Steve as comfortable as possible. In addition to treating Steve's physical symptoms, our team offers a full range of services, even psychological and spiritual care. We have counselors, chaplains, social workers, massage therapists, pharmacists, nutritionists, you name it – whatever is needed, we can address. We also provide support services to sustain your entire family."

Emma shook her head. "No, no, that's not . . ."

Dr. Able then spent more than 10 minutes explaining the history and nature of palliative care in a manner that made Emma feel like a student in elementary school. "Class is over," Emma thought, finally deciding to comment. But what came out of Emma's mouth was surprising even to herself.

"We *get it*, Dr. Able," Emma said sarcastically. "Our family is *very* smart."

"Emma!" Dr. Able gasped. "You don't need to attack me!"

"I'm not," Emma said. "I'm not."

Dr. Able left the room, stunned and angry. Steve was sound asleep. Emma looked at her mother and sister-in-law and said, "It didn't come out right. What I wanted to say was that I didn't want Steve to have palliative care because I want the doctors to SAVE him. If we move him to that unit, they will just let him die."

**Training Tools #60–1**

**Two role plays on creating more realistic expectations among patients**

# Role plays on managing patient expectations

**TYPE:** Role plays – physician (or other provider) and patient

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Patient expectations, customer service, improving patient relationships

**OBJECTIVE:**

- to practice managing patients' expectations in situations when there is no truth – or partial truth – behind their reasoning.

**MATERIALS NEEDED:** A copy of the two roles for each dyad for the selected exercise, and a copy of the discussion sheet for all participants

**PROCEDURE:**

Ask each participant to select a partner and distribute the confidential instructions for the selected exercise so that persons in each dyad are playing opposing roles. Your choices are:

- **The magic pill** – A patient demands an antibiotic for a common cold. (Select this exercise if you want to show a situation in which the patient's expectations are erroneous.)
- **Just my luck** – A patient expecting the worst is fearful of needed surgery. (Select this exercise if you want to show a situation in which there are some truths behind a patient's fears that lead to exaggerated concerns.)

Tell participants that they will have 10 minutes for the role play.

**DEBRIEFING:**

After the role play, distribute the discussion sheet for the selected case to all participants and ask them to spend 10 minutes discussing the questions with their partner. In the remaining 10 minutes, bring participants back together so that each dyad can present their most significant lessons about expectation management with the group as a whole.

## Training Tool #60

### ROLE PLAY: THE MAGIC PILL
CONFIDENTIAL INSTRUCTIONS

**Patient – Mrs. Coffman**

You are a 42-year-old woman with such a bad cold that you have been unable to sleep uninterrupted for an entire week. The sneezing, coughing, runny nose and sore throat have been practically unbearable, not to mention the fatigue. Because you've been getting up frequently to blow your nose and cough each night, your husband has been sleeping in another room.

You've been doing everything that you've always been told to do for colds: taking as many naps as you can (to catch up on the sleep you miss at night); drinking plenty of liquids, especially water, juice, and hot chamomile tea; and trying to stay warm. Although you don't have much appetite, you have tried to maintain your strength with an occasional bowl of chicken soup. Throat lozenges and ibuprofen seem to offer temporary relief, but not nearly enough. You feel completely miserable.

You decided not to go to work this week, not only because you feel so poorly, but also to avoid exposing your coworkers. But with an important meeting coming up, you believe it's important to get back to work as soon as possible.

When you've had bad colds in the past, you remember how much better you felt after your doctor finally relented and gave you an antibiotic. You believe it's necessary to get an antibiotic now for three reasons: first, you need to return to work; second, your nasal discharge is now a putrid green; and third, your symptoms have lasted longer than five days. Thankfully, Dr. Waite had a cancellation, so you will go his office today.

While driving to Dr. Waite's office, you smiled when you imagined how much better you will feel after this visit. You fully expect to get the prescription for an antibiotic. How could any doctor refuse to help when seeing how sick you are, green sputum and all? You also expect that you will not be contagious as soon as you start taking the pills. You can go to work tomorrow, and your husband can sleep in his own room tonight!

Even if the doctor tells you again that antibiotics are ineffective against cold viruses, you will argue that you know they DO work on colds. After all, why is it that you felt better whenever you've gotten antibiotic prescriptions for colds from Dr. Waite in the past? As for antibiotic resistance, too bad; you want immediate relief! If all else fails, you'll nag. Your husband says you excel at it.

## Training Tool #60

### ROLE PLAY: THE MAGIC PILL
CONFIDENTIAL INSTRUCTIONS

**Physician – Dr. Waite**

In a few minutes, you will see Mrs. Coffman, a 42-year-old woman who made an appointment for a bad cold. While you will check her for bronchitis and other complications, you strongly suspect that this will be nothing more than another common cold. Mrs. Coffman is prone to them.

Against your better judgment, you've given Mrs. Coffman antibiotics for several colds she has had in the past. Although you explained to her each time that a cold is a virus and antibiotics don't work on viruses, she wouldn't take no for an answer. When her insistence started to gnaw on you, it seemed easier to write a quick prescription. You now regret giving in.

If this is once again only a common cold (which you will find on today's visit is all it is), you will no longer prescribe an unnecessary antibiotic. Years ago, you believed that antibiotics would do no harm, even for persons with viruses. Now you know that the overuse of antibiotics results in antibiotic-resistant infections. This is becoming a worldwide problem, causing pharmaceutical companies to develop stronger and stronger medications, which no doubt will be linked to many harsh side effects. You also are now aware that antibiotics can make colds worse because they kill the beneficial bacteria.

You know that Mrs. Coffman most likely feels awful – who doesn't when they have a bad cold? But this is a great opportunity to educate her about what will help and what won't, thus readjusting this patient's expectations.

## Training Tool #60

### ROLE PLAY: THE MAGIC PILL

DISCUSSION SHEET

1 What questions did Dr. Waite ask to identify Mrs. Coffman's expectations?
2 How did the doctor address the patient's concerns?
3 When correcting the misinformation that was guiding Mrs. Coffman's thought process, was this done in a way that allowed Mrs. Coffman to save face? Why is face-saving important to expectation management?
4 To what extent was Dr. Waite successful in convincing Mrs. Coffman to have more reasonable expectations about the course and treatment of her cold?
5 Since Mrs. Coffman was more concerned about immediate relief than the global effects of antibiotic resistance, how were these differing views reconciled?
6 What did you learn about the management of patient expectations from this exercise?

## Training Tool #61

### ROLE PLAY: JUST MY LUCK
CONFIDENTIAL INSTRUCTIONS

**Patient – Sue Nommy**

You are Sue Nommy, a 62-year-old widow whose husband died three years ago in a freak accident. It's no wonder. It has always seemed to you that you were born with bad luck. For you, whenever anything can go wrong, it will. Everyone you know, even your doctor, is aware of your many superstitions.

True to legend, your bad luck seems to come in threes. Just lately, for example, your car was nearly totaled when a reckless driver hit it in the grocery store parking lot, so you are now driving a loaner car from the dealership. Now your doctor tells you that you will need to have a complete hysterectomy. Because you are not a candidate for a vaginal hysterectomy, you were told to plan on a hospital stay of two to four days.

That's two bad things that have happened, and you've now figured out the third: something will go wrong during your hospital stay! You don't think that problems will develop during the surgery itself, as Dr. Reasoner is an excellent physician who has earned your utmost trust and respect. What you do fear is catching something in the hospital. You had a bad feeling when you read an article in the beauty shop about the new superbugs that are found in many hospitals these days. You cut out the article and highlighted the section about MRSAs, which the article explains is "methicillin-resistant staphylococcus aureus." You think it was destiny that you saw this article and plan to show it to Dr. Reasoner today.

During today's visit, you will tell Dr. Reasoner that you don't think it's a good idea for you to have the surgery – not because of the surgery itself, but because you believe that you will catch something during your hospital stay. By showing Dr. Reasoner the article you clipped out, you plan to prove that you aren't imagining things. As the article shows, MSRAs cause more invasive infections in the USA than the human immunodeficiency virus (HIV). You are quite sure that if there are any superbugs lurking in the hospital, it will be just your luck to catch it. As you'll tell Dr. Reasoner, you're thinking that it may be better to stick with the endometriosis and fibroid tumor than risk something worse.

## Training Tool #61

### ROLE PLAY: JUST MY LUCK
CONFIDENTIAL INSTRUCTIONS

**Physician – Dr. Reasoner**

Today you will see Sue Nommy, a 62-year-old widow with many superstitious beliefs. You recently had to tell Sue that, due to her worsening endometriosis and a fibroid tumor, she will need a hysterectomy. Because she is not a candidate for a vaginal hysterectomy (and also because of her weakened immune system), you told her to expect to stay in the hospital between two and four days.

You plan to check Sue once again and make plans for her surgery, but you expect some resistance. Sue always seems to have some superstitious reason for delaying needed treatments.

You hope this visit won't take as long as usual, because you have an important meeting to attend at your hospital immediately after. You have just been named as the head of the hospital's Infection Control Committee, and you've called for a meeting that will begin in half an hour. This is a subject that is of great interest to you, because you have been very concerned about rising nosocomial infection rates – not only at your hospital, but in many hospitals throughout the country. It concerns you deeply that as many as one in 10 patients have acquired a nosocomial infection after their hospital stays, even though nearly one-third of these are preventable. You are particularly concerned about reports from other hospitals that have identified MRSAs. Although your hospital has not found any evidence of these particular superbugs as of yet, you want to take every necessary precaution and be prepared for the possibility. You also want to do what you can to reduce the current rate of infections at the hospital.

For now, you'll try to put that out of your mind so that you can focus on Sue. You wonder what she'll be nervous about today. You will use your best persuasive skills to convince Sue of the need to schedule the surgery as soon as possible. In your opinion, that is not an option.

## Training Tool #61

### ROLE PLAY: JUST MY LUCK
DISCUSSION SHEET

1 Regardless of whether Sue was forthcoming about her expectations and concerns, did Dr. Reasoner ask questions about them? Why is this important to do before trying to manage a patient's expectations?
2 Would your strategies for managing a patient's expectations be any different when dealing with patients that want to avoid something (for fear of bad consequences) than when you are dealing with patients who want something (with the expectation of good outcomes)? Please explain.
3 Did the doctor convince Sue to schedule the surgery? By the end of the visit, did Sue feel less worried about acquiring infections from the hospital? If so, what strategies worked best?
4 Because Sue's concerns about hospital-acquired infections were concerns shared by Dr. Reasoner, how did the doctor address Sue's concerns? How did the doctor maintain a balance between telling the truth and assuaging her concerns so that she wouldn't exaggerate the risk in her mind?
5 What did this exercise teach you about managing patients whose expectations are based on factual information, even if their fears are overblown?

# Confidentiality and privacy issues

## Training Tool #62

**Identifying issues involved in patient confidentiality/ privacy**

# Confidentiality in health care settings

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Confidentiality/privacy

**OBJECTIVES:**

- to introduce the topic of confidentiality/privacy issues in health care settings;
- to raise awareness of patient needs for privacy/confidentiality;
- to identify possible causes of breaches.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Lead the group in a discussion of the following questions.

1 Why is the topic of confidentiality/privacy even more important in health care than in many other industries?
2 What confidentiality/privacy concerns do you or your family members have when seeking health care services? What concerns have you heard patients express?
3 What temptations or behavioral tendencies might inadvertently cause health care professionals to engage in breaches of confidentiality?
4 What other major challenges in protecting patient privacy do health care professionals typically face?

**DEBRIEFING:**

Summarize the group's responses and use this discussion as the springboard for a brief lecture on confidentiality/privacy issues in health care.

**Identifying suitable locations for discussing private information**

## Training Tool #63

# A place for everything

**TYPE:** Worksheet

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Confidentiality/privacy

**OBJECTIVES:**

- to raise awareness about the need to discuss private or confidential matters in areas that are out of earshot of others;
- to consider locations that are safe for such discussions in participants' health care settings.

**MATERIALS NEEDED:** A copy of the worksheet for all participants

**PROCEDURE:**

Explain that while health care professionals are often so busy that they may want to convey information to colleagues, patients, and others whenever and wherever they get the chance, it is nevertheless essential to discuss private or confidential matters out of earshot of others.

After dividing into small groups, distribute the worksheet to all participants and ask them to fill in the boxes with lists of unsuitable and suitable locations for discussing private information in hospital and ambulatory settings. Allow 15 minutes for the completion of the list.

**DEBRIEFING:**

Bring the entire group back together and ask these questions about locations for private/confidential discussions:

1 What did your group cite as *unsuitable* locations in ambulatory settings?
(Responses may include the reception area and busy hallways.)

2 What were your responses for *suitable* locations in ambulatory settings?
(Responses may include exam rooms and providers' offices.)

3 What did your group list as *unsuitable* locations in hospital settings?
(Responses may include elevators with other passengers; blind corners in hallways, when you can't see who is around the corner; and nursing stations, when other persons are present.)

4 What did your group identify as *suitable* locations in hospital settings?

(Responses may include patient rooms, family rooms/private lounges, and conference rooms.)

5 What areas afford the most privacy in your practice site(s)?

6 What can you do to compensate for situations or conditions that make privacy difficult; for example, thin or non-soundproof walls, conversing with patients who have hearing problems, conducting private telephone conversations if you work in an open area or cubicle, etc.?

## Worksheet: Locations

| | Unsuitable locations | Suitable locations |
|---|---|---|
| Hospital settings | | |
| Ambulatory settings | | |

## Training Tool #64

**Confidentiality/ privacy issues concerning use of the telephone**

# On the line

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Confidentiality/privacy

**OBJECTIVES:**

- to show the challenges regarding patient confidentiality/privacy that can arise from environmental conditions or the use of various technologies;
- to identify ways to enhance the protection of patient information when using the phone.

**MATERIALS NEEDED:** Copies of the discussion sheet on the following page for all participants

**PROCEDURE:**

Distribute a copy of the discussion sheet to all participants. Select participants to read each dilemma aloud to the group, one by one, noting that you have given everyone the sheet so that they can refer back to each situation. After each scenario is read, engage in a group discussion about how it should be handled.

**DEBRIEFING:**

While each situation requires different solutions, ask the group to identify any common themes in their responses. Close this discussion by noting that telephone use is not the only challenge regarding communication technologies; the use of fax machines, Blackberries, and other devices pose confidentiality/privacy dilemmas too.

## Training Tool #64

### INTRODUCTORY DISCUSSION: ON THE LINE

DISCUSSION SHEET

What should you do in each of these situations involving use of the telephone in order to maintain patient confidentiality/privacy?

1 **Cubicles.** You are a nurse in a public health center who works out of a cubicle surrounded by several colleagues. It concerns you deeply that patient confidentiality is not being maintained because the sound easily carries and your colleagues can hear everything you say on the phone. You have no other place to return patient calls other than from your desk. What can you do?

2 **Answering machines.** As a telephone triage nurse in a large group practice, you have just been asked to notify 35 patients about lab test results. When you can't reach patients directly either at home or work, should you leave detailed messages on their answering machines or voice mail? You'd like to get this task done; you'll probably have 35 more people to call tomorrow!

3 **Cell phones.** A physician in your practice tries to save time by returning telephone calls to patients while driving to/from the hospital and long-term care facility. You have just attended a session on confidentiality/privacy and fear that these cell phone conversations can be intercepted. You are in a non-management position and wonder if it's your place to say anything. Your family suggests minding your own business. What should you do?

## Training Tools #65–9

**A selection of case studies to explore various aspects of confidentiality/ privacy issues**

# Case studies on confidentiality/ privacy

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 60 minutes (for three cases)

**THEME:** Confidentiality/privacy

**OBJECTIVE:**

- to identify possible solutions to confidentiality/privacy dilemmas in challenging situations.

**MATERIALS NEEDED:** A copy of three selected case studies for all participants

**PROCEDURE:**

During a brief lecture on confidentiality/privacy in health care settings, note that maintaining people's confidences requires skillful decision making in various types of situations. Then divide into small groups and distribute the three case studies you have selected. Your choices are:

- **The promise** – After promising confidentiality, a PA learns that the patient has abused her children.
- **Ms. Mouth** – The medical records department wants to cross-train the office gossip.
- **Pressure at home** – A nurse's husband insists on hearing juicy stories from the ER.
- **The inquiring spouse** – A patient urges a physician not to notify his wife that he has genital herpes.
- **In plain sight** – A member of the front-office staff wonders whether to report a coworker who leaves patient records unattended.

Tell the group to devote no more than 10–15 minutes to address the questions following each case study. Wrap up the session with an all-group discussion.

**DEBRIEFING:**

As you compare the small groups' responses, mention the following points:

- There are several possible options for each of the cases.
- The preferred option will depend on your interpretation of the situation, applicable Federal and State laws/regulations, and your organization's policies.

- While some options seem clear-cut when reading about these situations on paper, choices may be less obvious when involving real people and working relationships.
- Also consider the perspectives of each party, individual privacy concerns versus the greater good, and the importance of effective communication.

## Training Tool #65

### CASE STUDY: THE PROMISE

Jane Smith, a new patient, tells her physician assistant that she has a problem trusting anyone, including health care professionals. She notes that she has an extremely private matter to discuss, but is fearful about revealing the information.

Noting his professional ethics, the PA promises to keep the information confidential. Relieved, Jane reveals that she has an anger problem and has been physically abusing her children. The PA asks Jane to bring her children in for immediate treatment and refers Jane to a counseling center. At the same time, he fears for the children's safety.

### DISCUSSION QUESTIONS

1 Given that the PA will need to report this to authorities, how should the PA explain this to Jane? Would it matter if Jane is told before or after the report is made? Please explain.
2 Is it advisable to promise confidentiality without knowing the nature of the issue? Or should a promise of confidentiality have qualifiers; for example, "as long as it's not illegal"? What is the best way to phrase a promise of confidentiality without hemming yourself in?
3 What local, State, or Federal laws/regulations are applicable to this situation? If you don't know, how will you find out?

## Training Tool #66

### CASE STUDY: MS. MOUTH

You are the clinic coordinator in a busy, short-staffed community health center. Recently, the manager of your medical records department asked for permission to cross-train another staff member to help update the medical charts.

You thought this was a good idea until you were told that there's only one staff member with available time to do this, Mindy Mouth. Mindy is a capable office assistant who does her work quickly and accurately, but has a well-deserved reputation as "office gossip."

### DISCUSSION QUESTIONS

1 What do you think is the psychology behind Mindy's propensity to spread gossip?
2 Should you allow Mindy to be cross-trained to handle patient information? If so, what precautions should you take?
3 Even if you found someone else to cross-train, how would you instruct that person to protect patient confidentiality and privacy? Would your instructions to Mindy be any different? If so, how?
4 How would you address the need for medical records personnel to maintain patient confidentiality at all times – even during off-hours?

## Training Tool #67

### CASE STUDY: PRESSURE AT HOME

Debbie Daybreak, RN, has been getting a lot of pressure from her new husband, Dan, to tell him more about interesting cases she sees in the hospital emergency room. "If you don't trust me enough to tell me, we don't have much of a marriage," he says. "I tell you things about people I meet in the real estate industry, and this should be a two-way street."

Debbie knows that Dan isn't interested in the more usual parts of her job; he doesn't seem interested in how many patients with myocardial infarctions she sees, or how many kids she treats with broken arms and legs. He wants to hear about the shocking and bizarre things that Debbie has seen in the ER – and he wants all the details.

In fact, Debbie does have a lot of "juicy" stories to share, but she's torn. She wants to prove to Dan that she trusts him completely, yet she wants to maintain her professional confidences. When she asked one of her nursing colleagues what she would do, her colleague said, "What's the big deal? I always tell my husband everything that happens here."

### DISCUSSION QUESTIONS

1 Would it be all right to tell Dan about cases if she doesn't refer to patients by name? After all, don't health care professionals often mention patient cases when giving lectures at medical and nursing conferences? What would be the difference?
2 Would it matter if Debbie's hospital is located in a large urban area rather than a small rural community, since stories are less likely to be identified with certain individuals? Why or why not?
3 If Debbie does agree to tell Dan some of her experiences when she is certain that patients wouldn't be identified, where should she draw the line?
4 What are the possible consequences if Dan shares his wife's stories with others and the patients' stories start circulating around town?

## Training Tool #68

### CASE STUDY: THE INQUIRING SPOUSE

Bill and Linda have been married for 10 years. Linda suspects that Bill has a medical condition that he has not been telling her about. She knows that he has made several recent visits to their physician, Dr. Quandary, but Bill has been somewhat secretive about the reasons why.

Linda is worried that there is something seriously wrong with Bill, and wonders if he is trying to keep her from worrying. Yesterday, she left a message for Dr. Quandary to call her back. When the doctor returned the call and Linda asked about the reason for Bill's visits, Dr. Quandary replied, "I'm not at liberty to say, Linda. You'd better talk to Bill."

Bill told Dr. Quandary that he does NOT want Linda to know that he has been diagnosed with genital herpes; he believes this will alert Linda to the fact that he has been having an extramarital affair. He assured Dr. Quandary of his precautions to ensure that Linda is not exposed. Dr. Quandary urged Bill to talk to Linda himself, but thus far, Bill has not done that and the doctor wonders when or if he will.

### DISCUSSION QUESTIONS

1 If Bill does not tell Linda about his diagnosis, should Dr. Quandary tell her? Please explain.
2 Would the way Dr. Quandary handles this situation be different if the wife was not a patient as well? Why or why not?
3 Since Bill's problem can affect Linda, should there be a point at which the doctor should tell Linda about this if Bill doesn't? Please explain.
4 If the medical problem involved a heart problem rather than genital herpes, would that affect the doctor's decision to tell or not tell the spouse?
5 Does it matter that Bill explicitly told the doctor NOT to tell his wife?

## Training Tool #69

### CASE STUDY: IN PLAIN SIGHT

You share a workstation with a colleague who often leaves patient records unattended and in open view. On several occasions, you have asked your colleague to exercise more caution, noting that you could be blamed for this infraction as well. Your colleague says that she needs to respond immediately when the physician or others need her, and often does not have time to secure the files.

While you consider this colleague to be a dear friend, you are upset that she has not changed her behavior despite your repeated warnings. You are thinking of discussing this matter with the practice's privacy officer, but realize that she'll know it was you who "ratted on her" and you'll still have to work side-by-side.

### DISCUSSION QUESTIONS

1 Is it your responsibility to report your colleague to the practice's privacy officer?
2 Would it matter if your motivation for reporting your colleague was to avoid being blamed for her carelessness rather than your interest in protecting patient privacy?
3 To what extent would your decision on how to handle this matter be affected by your friendship with your colleague?
4 What can be done to ensure that patient records are secured when the person responsible for the records is extremely rushed?

**Practice leaders discuss ways to keep a celebrity patient's information confidential**

## Training Tool #70

# Celebrity secrets

**TYPE:** Role play – various

**ESTIMATED TRAINING TIME:** 45 minutes

**THEME:** Confidentiality/privacy

**OBJECTIVES:**

- to show that confidentiality/privacy protections in health care settings may require additional measures in special circumstances;
- to raise awareness of the need to give all patients "celebrity treatment" in terms of confidentiality and privacy.

**MATERIALS NEEDED:** A copy of the role-play instructions for all participants

**PROCEDURE:**

Ask participants to break into small groups of four to five persons and distribute the instruction sheet to everyone. Explain that each person in the group will serve as a member of their hospital's HIPAA Steering Committee, which is responsible for establishing and enforcing confidentiality and privacy policies. As explained in the instruction sheet, note that they will have 25 minutes to develop a list of recommendations for protecting the privacy of a celebrity who will soon be admitted to the hospital for a substance abuse problem. Following the exercise, reconvene participants for an all-group discussion.

**DEBRIEFING:**

1 What extra measures did your group suggest for protecting Ivana's confidentiality/privacy?
2 What was suggested in regard to the prevention of leaks to the media or members of the public?
3 How could hospital leaders advise staff members to resist the temptation of sharing news about their celebrity patient?
4 What did your group suggest to keep the nature of Ivana's problem private? Did you take safeguards regarding access to Ivana's records on the EMR?
5 How could the precautions taken for a celebrity's confidentiality/privacy be extended to "regular folks"? In other words, what are the best ways to give all patients "celebrity treatment" when it comes to confidentiality/privacy?

## Training Tool #70

### ROLE PLAY: CELEBRITY SECRETS
INSTRUCTION SHEET

The hospital administrator has asked you and other members of the HIPAA Steering Committee to hold a special meeting to determine what extra measures can be taken to protect the privacy of a celebrity who will be admitted to the hospital within a few days: Ivana B. Serene, an internationally known rock musician and actress. As the administrator explained, Ivana, age 44, will be treated for a life-threatening substance abuse problem. It will be her fourth attempt at rehabilitation, but the first time in your medical center. Because your hospital is fairly new and has never had a celebrity patient before, your committee will need to develop its recommendations from scratch. More than 600 full-time and part-time personnel work at your hospital.

The administrator related numerous points about Ivana and her imminent admission:

- Like many other celebrities with drug abuse problems, Ivana is a deeply troubled individual. Having undergone a difficult childhood, Ivana leads a high-pressured life, often on tour with her rock band or on location for movies. While constantly battling her inner demons as well as her alcohol and drug addictions, she tries to be a good mother to her 12-year-old daughter.
- The paparazzi have been swarming around her for years, taking photos of her even in private moments. It has especially bothered Ivana when photos are taken of her daughter without her consent. Paparazzi will be a major problem if there is a leak about Ivana's admission.
- Ivana's agent said that numerous precautions have been taken on their end to keep her admission a secret; for example, they will bring her to the hospital in a nondescript car and she will wear a disguise when entering the hospital.
- The public is generally aware of Ivana's alcohol addiction; however, it has not been revealed that, on this visit, she will be treated for heroin addiction as well. The agent has asked the hospital to do everything in its power to keep this information private.
- The agent has expressed concern that if fans, paparazzi, or anyone other than the immediate family finds a way to interrupt Ivana's hospital stay, her rehabilitation could be jeopardized. Because of the severity of her condition, the agent believes that, without the completion of her treatment, her life could be imperiled.

The administrator noted that she is willing to entertain any request for funding that the committee needs in order to ensure Ivana's privacy, so money should not be considered an obstacle. The administrator suggests covering all aspects of Ivana's visit when developing your recommendations.

## Training Tool #71

**A public policy debate on contraceptive services for unmarried minors**

# Sex in the city

**TYPE:** Role play – five roles

**ESTIMATED TRAINING TIME:** 90 minutes

**THEME:** Confidentiality/privacy

**OBJECTIVES:**

- to explore a public policy issue dealing with confidentiality for minors seeking contraceptive services;
- to identify and reconcile differing views on a controversial public health topic.

**MATERIALS NEEDED:** A copy of the "General Instructions" for everyone, and a copy of the five roles for each group

**PROCEDURE:**

Ask each participant to break into groups of five and distribute a different role to persons in each group. If there are extra persons, ask them to double up on roles with another character. Give the groups 60 minutes to complete the exercise and then bring them back for an all-group discussion. Tell participants that they may embellish their roles by adding their own comments as long as the points they raise are consistent with their character. Also note that they may alter their positions only if the arguments they hear would convince them to do so if this were a real-life situation.

**DEBRIEFING:**

1 Was it possible to reach consensus within the time limit for this exercise? Why or why not? If your group didn't reach consensus, what were the obstacles?
2 What specific issues were most important to each party?
3 What, if any, were the common interests among the parties? How did their interests vary?
4 Did any of the parties align with others? If so, which? Why?
5 What were the areas of agreement? (For example, did parties agree that efforts should be made to encourage parent-child communication about sexual health? What did they decide about confidentiality for minors? What about public access to medical records?)
6 If you played a role that did not support your own views, what did you learn from seeing this situation through another's eyes?

7 What strategies were used to reach consensus among persons/groups with such disparate and strongly held views?
8 Did your group identify any creative solutions regarding prevention or other matters?
9 What did you learn most from this exercise about issues concerning confidentiality in health care?

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY

GENERAL INSTRUCTIONS

Despite the fact that the teen pregnancy rate in your State has exploded in recent years, yours is one of the few States that currently has no explicit policy on minors' authority to obtain contraceptive services. The Governor has called for a public debate on this subject.

Because many organizations, agencies, and interest groups throughout the State have expressed a broad spectrum of views on contraceptives for minors (defined by your State as age 18 or younger), the Governor has called upon representatives from the following groups to meet to see if consensus is possible on this topic:

- State Department of Public Health
- Parents' Right to Know Coalition
- Planned Parenthood
- State Medical Society
- Abstinence-Only Coalition

The meeting has been scheduled for today. The Governor will not be present, but has designated the official from the State Department of Public Health to serve as facilitator. Whatever decision the group reaches will form the basis of draft legislation. The Governor's preference is to require parental consent before contraceptives may be prescribed, but will go along with whatever decision this group makes.

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY
CONFIDENTIAL INSTRUCTIONS

**State Health Department Official**

While the Governor has designated you as the facilitator for this meeting, you also plan to represent the State Health Department's position, which is to allow minors to obtain contraceptive services without parental consent and with guarantees for the confidentiality of minors who seek such services. Even though you will articulate your department's position, you will try to be open to others' ideas in your role of facilitator.

The high teenage pregnancy rates in your State are a major concern in your department. In surrounding States, the number of births to teenagers is around 35 per 1000. In your State, the rate is nearly double that. In addition to the health risks to pregnant teenagers themselves, teen pregnancies have numerous other effects; for example:

- Teenage girls who have babies are more likely to not finish high school, leading to less income and, in some cases, lifelong poverty and insufficient access to health care.
- The babies of teenage mothers have a greater chance of having a lower birth weight, which can lead to numerous health problems throughout their lives.
- The Women, Infants, and Children (WIC) program in your State is overloaded and under-funded as it is. You are deeply concerned that the system will become even more strained if something isn't done to stem the number of teenage pregnancies.
- Your department sees the possibility of obtaining more access to Federal funding as a major benefit of providing contraceptive services. You would like to obtain funding from the State Children's Health Insurance Program, which offers a wide range of contraceptive services to children, such as oral contraceptives, contraceptive implants, and "the morning-after pill." To date, your State has not taken advantage of these funds. If you do receive funds from Title X or Medicaid for contraceptive services, your State will have to treat all patients confidentially, regardless of age. (It's your decision whether to mention during the meeting that this has not stopped some States from introducing legislation that would mandate parental involvement, but States that do this are likely to face court challenges.)

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY
CONFIDENTIAL INSTRUCTIONS

**Representative – Parents' Right to Know Coalition**

The first choice of your coalition is that contraceptive services should not be available to minors; your members believe that this will increase their sexual activity. While you will try to get this point across, you will go along with the provision of those services ONLY if you are assured of the right of parents to prevail in any health care decision concerning a child. Key points that you will address at today's meeting may include the following:

- You believe that any legislation that allows minors to obtain contraceptives without parental consent would usurp parents' rights to direct the upbringing of their own children, thus driving a wedge in the parent-child relationship.
- If both parents are living, you believe that physicians should be required to physically locate and notify both parents, whether or not they reside in the same household. (You may be flexible on this point, as some members of your coalition believe that only one parent needs to be notified.)
- You believe that minors lack the experience and judgment necessary to make fully informed decisions – especially on life-altering matters such as this one.
- You believe that "confidentiality" for minors is a dangerous concept. Your coalition was created to ensure that parents maintain their right to know what is going on with their own children – even on sensitive matters such as premarital sex.
- If teenagers are allowed to bypass their parents and obtain contraceptives directly from public health departments, community clinics, and private medical practices, you believe that will send the message to teens that it's acceptable to withhold information from parents on other matters as well.

You also plan to mention that approximately 60% of teens seeking contraceptive services *do* tell their parents. You want to encourage more teens seeking these services to do the same.

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY
CONFIDENTIAL INSTRUCTIONS

**Representative – Planned Parenthood**

Your organization believes that parental consent should not be necessary for a minor who seeks an abortion, so you certainly don't believe that parental consent should be required for minors who seek contraceptive services. Other key points that you plan to raise during this meeting include the following:

- You strongly believe that making contraceptives more available to teens has important advantages: it will reduce the number of unwanted pregnancies and will be better for minors' health.
- You are appalled that some people believe that making contraceptive services less available will curtail the sexual activity among minors. Only 1% of teens say that would keep them from having sex!
- Studies have shown that many minors (70%) will not seek sexual health services if their parents will be told that they are seeking prescriptions for contraception. According to multiple studies, complete confidentiality is the most important factor to teens in their decision to seek sexual health services. Without it, the pregnancy rate among teens would skyrocket even more. Studies have shown that one-quarter of the teens who would not notify their parents would simply continue to have sex without any contraceptives.
- You agree with the point made by parents' organizations that there should be greater communication between parents and children in regard to sexual activity and sexual health. Even so, you maintain that parental notification should be the decision of the teens and should not be mandated.
- In regard to suggestions that minors would need permission from both parents, you will ask about the effect on the many minors who live in one-parent homes, a large number of whom have not seen their divorced fathers for more than a year.
- In addition to your belief that confidentiality must be assured for teens seeking sexual health services, you strongly support adding a provision that confidential medical records may not be subpoenaed by anyone.

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY
CONFIDENTIAL INSTRUCTIONS

**State Medical Society**

The State Medical Society's position on contraceptive services for youth is that it should be up to each individual physician whether to provide these services. For physicians that do provide these services, they should be able to protect their patients' confidentiality – regardless of age. Other points you will make during this meeting include the following:

- The status quo – having no State policy regarding minors' authority to consent to contraceptive services – is untenable. This is causing a great deal of confusion for your members in their respective practices.
- The Society is very concerned about the increasing rates of pregnancies and STDs among adolescents. The health of teens should be paramount.
- Your members do not have the time or inclination to go out and physically locate parents and seek their permission; nor do your members believe this is in minors' best interest.
- You also believe that confidentiality is essential because multiple studies have shown that mandatory parental notification will not be effective in preventing minors from engaging in sexual activity and will cause them to engage in unsafe sex.
- While parental involvement is desirable, you believe it's important to explore the reasons why 40% of teens will not seek contraceptive services if they are not promised complete confidentiality: studies of unmarried minors have shown that 30% of those who do not wish to inform their parents have histories of violence in their families. Many of these minors are afraid of being forced to leave their homes.
- The Society is strongly opposed to any laws requiring the sharing of medical information with government agencies or anyone else.

## Training Tool #71

### ROLE PLAY: SEX IN THE CITY
CONFIDENTIAL INSTRUCTIONS

**Abstinence-Only Coalition**

Your organization is strongly opposed to any Statewide policy that would allow minors to obtain contraception, period. After all, teens shouldn't be having sex in the first place! Other points you plan to raise at today's meeting include the following:

- You believe it sends confusing messages to minors when they are given information about safe sex or when contraceptive services are made easier for them to obtain. They should be educated in one way: just say no!
- You wonder why many of the people attending today's meeting do not get it – teen sexual activity has many serious health risks; for example, STDs and unwanted pregnancies. Why would anyone condone this?
- Many of your members are from religious communities that believe premarital sex is immoral.
- You believe that the increasing teen pregnancy rates in your State are largely due to the fact that parents are not doing their jobs in educating them about the risks of having sex. Parents should step up to the plate.
- You believe that organizations are doing a disservice when they support contraceptive services for teens, even when parental notification is required. If teens do not have sex in the first place, they will not need to worry about notifying anyone.
- Various members of your interest group have told you that you are likely to be outnumbered at this meeting and that it will be hard to sell your position to others. If you encounter significant resistance, they have authorized you to use your judgment and go along with the most conservative approach possible. They insist, however, that abstinence education be part of any decision the group makes.
- You believe that government officials or anyone else should be able to obtain the medical records of any health care facility providing reproductive health services to minors.

# Intercultural communication

## Training Tool #72

**Identifying and dispelling myths regarding intercultural health care**

# Dispelling the myths

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Intercultural communication, customer service, patient relationships

**OBJECTIVE:**

➥ to learn about intercultural communication by dissecting and correcting several untruths.

**MATERIALS NEEDED:** A copy of the "List of Myths" for all participants

**PROCEDURE:**

Distribute a copy of the "List of Myths" to all participants and explain that you will ask them to identify the reason why each item is incorrect. Allow time for participants to respond after reading each myth aloud. Correct answers are as follows.

1 **Developing cultural competency is mainly necessary for health professionals whose organizations serve large ethnic populations.** Cultural competency is essential for *all* health professionals, not only because populations are becoming increasingly diverse due to travel, immigration, and the global economy, but also because each individual has his/her own cultural fingerprint. As such, every patient encounter is cross-cultural to some degree.

2 **Generalizations and stereotypes are synonymous terms.** Generalizations are the acknowledgement that each cultural and ethnic group may share certain common attributes – a mental process that can be helpful in the provision of quality care. Stereotyping, on the other hand, involves an assumption that all or most individuals within a cultural or ethnic group are alike. This is a dangerous assumption because it doesn't take into account that there is great heterogeneity among and within each cultural and ethnic group.

3 **You should use the same formula for communicating with persons of any cultural or ethnic group.** While it's a good idea to learn mnemonic methods that provide a general framework for communication (such as the BATHE and ETHNIC techniques), your treatment and communication should be tailored to each individual.

4 **We can become more culturally competent simply through experience in dealing with people who are different from ourselves.** It takes a great deal of effort and learning to understand the complexities of intercultural communication that are

necessary for effective patient relationships, increasing patient compliance, and reducing disparities. Because cultural competence is a skill, developing this ability requires more than experience alone. Cognitive and behavioral training are necessary as well.

5 **Skin color is usually the best indicator of cultural differences.** Many of the differences between people are completely invisible. It's faulty thinking to assume that you can tell about people's ethnic backgrounds, traditions, religious and spiritual beliefs, sexual orientation, and other differences simply by looking at them.

6 **Folk remedies should be avoided because they are injurious to a person's health.** In some cultures, folk medicine plays a major psychological role, perhaps as much as medication does for the body. Not all folk remedies are harmful; in fact, substances that don't contain arsenic or lead may actually be helpful for their placebo effects. Importantly, however, remedies with poisonous properties should be discouraged for everyone – especially for children.

7 **A provider's personal attitudes and biases toward persons from a different cultural background will not affect the quality of care provided as long as those attitudes are not brought to the surface.** There are many ways that prejudicial attitudes can influence health care delivery, all of which are negative. Being culturally aware and exploring your own attitudes and biases will go a long way toward improving the quality of care you deliver.

8 **Diversity training is necessary only for physicians and other providers in health care organizations.** All members of the health care team should have diversity training, not only to deal effectively with multicultural patients, but also with one another.

**DEBRIEFING:**

1 What are other myths about intercultural health care? Please explain.

2 What can you do to ensure that generalizations do not become over-generalizations – and thus become stereotypes?

3 Even if you had a good grasp on why the statements on the "List of Myths" were not categorically accurate, what were your take-away lessons from this discussion?

4 How does it help to share opinions and information from your colleagues on this topic?

## Training Tool #72

### MYTH LIST

MYTHS ABOUT INTERCULTURAL HEALTH CARE

1 Developing cultural competency is mainly necessary for health professionals whose organizations serve large ethnic populations.
2 Generalizations and stereotypes are synonymous terms.
3 You should use the same formula for communicating with persons of any cultural or ethnic group.
4 We can become more culturally competent simply through experience in dealing with people who are different from ourselves.
5 Skin color is usually the best indicator of cultural differences.
6 In the interest of practicing modern medicine, folk remedies should be avoided because they are injurious to a person's health.
7 A provider's personal attitudes and biases toward persons from a different cultural background will not affect the quality of care provided as long as those attitudes are not brought to the surface.
8 Diversity training is necessary only for providers in health care organizations.

Critical considerations when seeing patients of different cultures

## Training Tool #73

# Communication essentials for multicultural care

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Intercultural communication, customer service, patient relationships

**OBJECTIVES:**

- to raise awareness about the need to communicate in ways that are culturally sensitive and meet each individual's distinct needs;
- to identify general communication principles and skills that can be applied to most intercultural encounters.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Tell participants that they are walking into an exam room to greet a new patient who recently immigrated to your country. As of yet, they know nothing about her nationality, culture, spiritual beliefs, religion, or language.

Then ask: "What types of communications and behaviors would be 'safe' to use with patients whose cultures you do not yet know about? For example, where should you sit/stand? What types of things should you say/not say?" Write the words "I would . . ." at the top of the flip chart and then list the group's responses.

The group's responses to the "I would" questions may include the following:

I would . . .

- identify their level of English comprehension and arrange for an interpreter if necessary;
- speak to the patient directly, even if an interpreter is used;
- begin by using the patient's formal name and/or ask how the patient wishes to be addressed;
- avoid nonverbal behaviors that could be interpreted as aggressive, such as sitting too close;
- avoid eye contact that is staring or too direct;
- use a speech rate and style that is understandable to the patient while demonstrating respect;
- ask open-ended questions and/or ask questions in several different ways.

**DEBRIEFING:**

1 Are there other communication principles you would like to add?
2 What types of questions would you ask in a culturally-competent interview to identify the patient's attitudes toward illness and health? (Answers may include: What brings you here? What do you call your illness/problem? What do you think has caused it? What have health professionals or family members done to treat the illness/problem so far? How has the illness/problem affected your life? What about this illness/problem worries you most? What would you like to have happen at today's visit?)
3 What can you do to avoid misunderstandings? How can you avoid inadvertently offending patients of other cultures?
4 While the best way to understand patients' cultures and beliefs is to ask them directly, what else can you do to learn about the predominant cultural groups in your practice? In particular, how can you learn more about patients' health beliefs and practices?
5 What aspects of this discussion helped you most to understand the need to conduct a culturally-competent interview with persons whose cultures you do not yet know about?

**Preparing a practice for an influx of patients from two ethnic groups**

## Training Tool #74

# The culturally friendly practice

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Intercultural communication, customer service, patient relationships

**OBJECTIVES:**

- to identify what could be done to prepare a practice for changes in the cultural composition of the patient population;
- to show the importance of seeing the practice from patients' perspectives so that it is welcoming to their respective cultures.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Tell participants to imagine that the population of two ethnic/cultural groups is increasing significantly in the area due to factors such as immigration and the global economy, and that this is affecting the mix of the patient population of their medical practice.

Tell participants which two ethnic/cultural groups you have selected as these populations and ask, "What will you recommend that will make your practice as culturally friendly and welcoming to these groups as possible?" Suggest looking at the practice from the viewpoint of the two ethnic/cultural groups and considering all aspects of the practice (e.g. the environment, processes, communication, etc.). Write responses on a flip chart and then ask the following questions.

**DEBRIEFING:**

1 By implementing this list of recommendations, which changes would be most noticeable to the two ethnic/cultural groups that are visiting the practice in greater numbers?
2 Which recommendations are most important? For example, is knowledge of these patients' cultures and the manner of communication more important than décor? Please explain.
3 How will the methods of patient education be changed for these ethnic/cultural groups? What about décor? Language? Signage? Posters and magazines? Attention to their predominant medical conditions? Staff training?

## Training Tools #75–8

**A selection of case studies on various aspects of intercultural communication**

# Case studies on intercultural communication

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 45 minutes (two cases)

**THEME:** Intercultural communication

**OBJECTIVE:**

- to dissect issues and identify strategies for dealing with various intercultural dilemmas.

**MATERIALS NEEDED:** A copy of two selected case studies for all participants

**PROCEDURE:**

Break into groups of five to seven people, and assign each group to discuss two of the following case studies. Note there will be 25 minutes for groups to identify relevant issues and develop recommendations for both assigned cases. Ask each group to designate a representative to give a group report following the discussion period. Your choices are as follows.

- **Coffee time** – An African-American administrative assistant resents being asked to get coffee for guests from the local hospital.
- **Professionally speaking** – A union employee seeks a job in patient relations despite poor English skills.
- **Take my advice** – Members of a medical practice discuss ways to bridge differences with a foreign medical graduate.
- **Traditional treatment** – A patient has been using traditional treatments that could be harmful to his health.

**DEBRIEFING:**

After hearing reports from each group, summarize the discussions to identify key learning points.

## Training Tool #75

### CASE STUDY: COFFEE TIME

There are 10 employees in your small health care organization. Your newest employee is an administrative assistant, and you are the executive director. Leaders from your local hospital have come to your organization for a meeting. You have asked the assistant to bring in coffee. Although she complies, she later tells you that she felt that asking her to get coffee was demeaning. The assistant, who is African-American, suggests that there were racial implications to your request. You are shocked and upset by these comments.

### DISCUSSION QUESTIONS

1 How should you respond to the assistant's comments?
2 What specific issues are involved?
3 How do perceptions vary from one party to another? To what extent are each party's perceptions related to intercultural differences?
4 How can you reconcile the need for teamwork within the organization and the assistant's perceptions that asking her to perform certain tasks is culturally insensitive?
5 What can these parties do to avoid misunderstandings or conflicts in the future?
6 Would you handle this situation differently if it were only a gender issue; that is, that the employee objected to being asked to get coffee because she's a woman? If so, how?

## Training Tool #76

### CASE STUDY: PROFESSIONALLY SPEAKING

You are the human resources director of a large hospital where a significant number of employees are unionized. One employee (a union member) is a 32-year-old female, originally from Guatemala. She has had excellent performance evaluations in several jobs she has held at the hospital since she began working there three years ago; all of those jobs were in Nutritional Services and Housekeeping. Recently, this employee applied for a job in "Patient Relations," a position that requires excellent writing and telephone skills. You do not believe that her proficiency in the English language is adequate for this position, and you are considering an applicant who has less hospital experience. The employee threatens to take this case to her union.

### DISCUSSION QUESTIONS

1 What would you do in this situation?
2 What specific issues are involved?
3 How do perceptions vary from one party to another? To what extent are each party's perceptions related to intercultural differences?
4 Which parties should be involved in discussions to work out the problem?
5 What, if any, are some creative solutions that would meet the needs of all parties?
6 Is this a case in which an attorney should be consulted?
7 What can these parties do to avoid conflicts in the future?

## Training Tool #77

### CASE STUDY: TAKE MY ADVICE

A new physician who received her medical training in a Middle Eastern country has recently joined your community health center. The new doctor feels somewhat intimidated in these new surroundings. Staff members have worked together for several years, and the doctor feels that she is being treated as an outsider. Some staff members have made suggestions to her to help her fit in, but the doctor does not wish to show weakness by taking their suggestions; instead, she often becomes defensive and dismisses their comments. Staff members feel an increasing distance with the doctor and their communication has become terse and cold.

### DISCUSSION QUESTIONS

1 What specific issues are involved?
2 How do perceptions vary from one party to another? To what extent are perceptions related to people's intercultural differences?
3 What should the doctor and staff do to bridge their differences and enhance their communication?

## Training Tool #78

### CASE STUDY: TRADITIONAL TREATMENT

As he looked at the chart, Dr. Lambert noticed that this was only the second time that Ana and Jorge Sanchez had brought one of their children to the Coastal Community Health Center since they moved to the USA from a small village in southern Mexico nearly a year ago. He was immediately struck by their worried expressions.

Today, the couple brought their baby, six-month old Alberto ("Beto"). Their other two children were at home with Ana's mother who just came to live with them.

"Dr. Lambert, we need your help," Ana said anxiously, trying to speak over the baby's cries. She quickly explained that Beto had a bad case of empacho (colic) and although she did everything she could for him, his symptoms were getting worse. In addition to the colic, Beto was extremely lethargic and hyperactive, and his stomach seemed upset.

Dr. Lambert took a blood test and grew very concerned that the lead levels in Beto's blood were more than seven times higher than normal.

"What did you do for Beto?" the doctor asked. Ana pointed out that she had used Alarcon, just as her mother did when she was a child, and just as she had treated her other two children when they had colic. Ana pointed out that this had been available to her family by curanderas (folk healers) and used for generations. Jorge agreed, noting that the curanderas are highly skilled practitioners, using natural herbs, minerals, and animal parts to make their medicines.

Dr. Lambert was familiar with this bright orange powder, a Mexican folk remedy that is often given to children for intestinal distress. He also knew that Alarcon was almost entirely composed of lead.

### DISCUSSION QUESTIONS

1 What should the doctor do to develop trust with this family, given that this is a fairly new relationship?
2 Considering their deeply rooted cultural traditions, should the doctor tell patients to completely give up their folk remedies? Why or why not?
3 How can Dr. Lambert show respect for the family's beliefs while educating them about the perils of Alarcon or Greta, both of which contain extremely high levels of lead?

Practicing the use of mnemonic devices for intercultural communication

## Training Tools #79–80

# Role plays on intercultural communication

**TYPE:** Role plays

**ESTIMATED TRAINING TIME:** 60 minutes (each)

**THEMES:** Intercultural communication, customer service, patient relationships

**OBJECTIVES:**

- to practice using one or more of mnemonic devices that can aid providers in intercultural communication;
- to raise awareness about the need for cultural sensitivity in all patient visits.

**MATERIALS NEEDED:** A copy of the "Intercultural Mnemonic Summary Sheet" for all participants; also, for the selected exercise, a copy of the two roles for each dyad, and a copy of the "Discussion Questions" for all participants (to be distributed later)

**PROCEDURE:**

Begin with a 20- to 30-minute lecture about one or more of the mnemonic devices that can aid in intercultural communication. These could include BATHE, LEARN, or ETHNIC. During this portion of the program, distribute the "Intercultural Mnemonic Summary Sheet" to all participants so that they can follow along and take notes.

*Note: The summaries of these techniques that appear in the summary sheet are brief descriptions that are intended to serve as reminders only. It is strongly recommended that you research these techniques to give more complete instruction on their use during your training session. Source material is listed below.*

Next, tell the group that they will be asked to practice one of the mnemonic devices that you described in your lecture by engaging in a role-play exercise. Ask each participant to select a partner and distribute the confidential instructions so that one person in each dyad plays the role of patient and the other plays the role of provider. Your choices are:

**Hard labor** – A young female migrant farm worker who is five months pregnant visits a new provider.

**Invisible differences** – A patient's cultural differences are not obvious to his provider.

Allow the dyads 20 minutes to conduct the role play. Tell participants that they may embellish "facts" as long as the points they raise are consistent with their character. Note

that after the 20-minute time limit, you will distribute a list of "Discussion Questions" that each dyad can address during the next 20 minutes. In the remaining 20 minutes, bring participants back for reports on their discussions.

**DEBRIEFING:**

After each dyad has reported to the group on their responses to the "Discussion Questions," summarize the major lessons about intercultural communication.

**SOURCE MATERIAL:**

For information about the mnemonic devices suggested in this exercise, you may wish to refer to the following sources:


BATHE

Stuart MR, Lieberman JA. *The Fifteen-Minute Hour: applied psychotherapy for the primary care physician*. 2nd ed. Westport, CT: Praeger; 1993.

McCulloch J, Ramesar S, Peterson H. Psychotherapy in primary care: the BATHE technique. *Am Fam Physician*. 1998; **57**(9): 2131–4.

LEARN

Berlin EA, Fowkes WC Jr. A teaching framework for cross-cultural health care. *West J Med*. 1983; **139**(6): 934–8.

ETHNIC

Levin SJ, Like RC, Gottlieb JE. ETHNIC: a framework for culturally competent clinical practice. *Patient Care*. 2000; **9**(special issue): 188.

## Training Tools #79–80

### INTERCULTURAL MNEMONIC SUMMARY SHEET

| **BATHE – to obtain the patient's psychosocial history** | |
|---|---|
| **B**ackground | Context: ask a general question about the patient's life |
| **A**ffect | Feelings: ask the patient about his/her feelings and mood |
| **T**rouble | Focus on the problem: ask what is most troubling |
| **H**andling | Functioning: ask how the patient is handling the problem |
| **E**mpathy | Support: understand and legitimize the patient's feelings |

| **LEARN – to obtain cultural, social, and cultural information by sharing perceptions** | |
|---|---|
| **L**isten | Listen sympathetically to the patient's perception of the problem |
| **E**xplain | Explain how you perceive the problem |
| **A**cknowledge | Identify differences/similarities between your perception and theirs |
| **R**ecommend | Recommend treatment |
| **N**egotiate | Negotiate agreement |

| **ETHNIC – to obtain information from the patient's cultural perspective** | |
|---|---|
| **E**xplanation | Ask why the patient thinks the problem developed; what concerns them |
| **T**reatment | Ask what the patient has done to take care of the problem |
| **H**ealers | Ask whether/how the patient been treated by folk healers/non-clinicians |
| **N**egotiate | Identify treatment options that are acceptable to both you and the patient |
| **I**ntervention | Determine an intervention that incorporates the patient's beliefs |
| **C**ollaboration | Work with the patient, family, healers, team members, and community |

## Training Tool #79

### ROLE PLAY: HARD LABOR
CONFIDENTIAL INSTRUCTIONS

**Maria**

You are a 17-year-old female who came to the USA from Puerto Rico with your parents two years ago and, except for long words and colloquial phrases, you have a fairly good grasp of conversational English. You and your parents work as migrant farm workers and travel throughout the East Coast Migrant Stream. Each winter, you begin from your home base in Florida, picking the winter crops, and then traveling up the Atlantic coast until you reach New York in the fall. The work is grueling, and you earn less than $7500 per year.

At the present time, you are halfway through this year's migration cycle. You didn't want to miss work by coming to the farmworker health center today – after all, when you don't work, you don't get paid – but your crew chief insisted that you seek medical care. You are five months pregnant, and because you haven't been feeling well for the past few months, your productivity is low and the crew chief keeps threatening to replace you.

Several medical problems have been concerning you, but you try not to complain because you don't want to lose your job. But if the provider asks (and promises not to tell your crew chief), you will admit that you are very tired; you're not sure if it's the hard work you do, or if it's because you're pregnant. You also get bad headaches, your joints hurt, and your skin, eyes, nose and throat are often irritated. At times, you get terrible cramps.

Depression is another major problem. In addition to being worried about supporting your baby, the 20-year-old father of your baby moved back to Puerto Rico a few months ago and you haven't spoken to him since. You doubt you ever will.

Thankfully, you haven't lost your appetite, and you try to eat as many fruits and vegetables as you can because you think it will be good for the baby. Although you're not supposed to, you sometimes eat a fruit or vegetable that you've just harvested. You don't take the time to walk back to camp to wash it off, even though the barracks are not far from the worksite. If what you are eating tastes like the spray they put on the fields, rubbing the fruit or vegetable on your shirt usually takes care of the bad taste.

You hope this visit doesn't take too long. If you get back in time, you still might be able to still put in a half-day of work. That's a half-day of pay you can definitely use.

## Training Tool #79

### ROLE PLAY: HARD LABOR
CONFIDENTIAL INSTRUCTIONS

**Provider**

As a provider at a farmworker health center on the East Coast of the USA, you find it difficult to provide continuity of care to your patients. As an example, take the case of Maria Lopez who is coming to see you today. You've never seen her and don't know much about her yet, only that she's 17 years old, unmarried, pregnant, and still working in the fields. It breaks your heart that this young woman is going through so much at such a tender age. Like your other patients who travel from one field to another, you don't know if you'll see Maria again.

You didn't get an interpreter because the receptionist noted that Maria speaks reasonably good conversational English. The receptionist also pointed out that Maria said she is coming in today because her crew chief insisted that she have a check-up. You have a feeling there's more to her story than this, and you've set aside ample time for this visit so that you can learn as much as you can about Maria and meet as many of her needs as you can.

As you try to uncover Maria's health issues and the direction that your interventions should take, you will apply one of the mnemonic devices (BATHE, LEARN, or ETHNIC). From your work at the farmworker health center for the last 10 years, you well know the need to provide culturally sensitive care.

## Training Tool #79

### ROLE PLAY: HARD LABOR
DISCUSSION QUESTIONS

1 Which mnemonic did the provider use for this visit? How well did it work in extracting the necessary medical and psychosocial information? What suggestions would help the provider improve their use of this mnemonic?
2 Was the mnemonic helpful in developing trust between provider and patient? Please explain your response.
3 What was particularly useful about following the mnemonic? What portion of the mnemonic, if any, was difficult to follow? Why?
4 Did the provider connect the dots between certain clues about Maria's problem; for example, that she could taste the pesticide spray on fruits and vegetables?
5 Did the provider uncover all relevant issues that were important to Maria's health? Was her pregnancy the only issue addressed, or was the possibility of pesticide poisoning also raised? Did the provider deal with Maria's depression?
6 How did the person playing the role of Maria perceive the cultural sensitivity of the provider?
7 How, if at all, was the issue of time addressed, given that Maria wanted to get back to work?
8 What interventions might be likely as a result of the interactions between Maria and the provider?

## Training Tool #80

### ROLE PLAY: INVISIBLE DIFFERENCES
CONFIDENTIAL INSTRUCTIONS

**Patient**

You are a 27-year-old Caucasian male who has just landed your dream job as a graphic designer in the advertising field. During the past three months, you have been fighting off what you believe are probably flu symptoms: fatigue, diarrhea, headache, muscle stiffness, and a sore throat. The sides of your throat feel quite swollen. You have taken OTC medications for the diarrhea and sore throat, but these only seem to mask the symptoms for short periods of time. You've been suffering these maladies for nearly three weeks (still not missing any work), but you have finally decided that it's time to get medical attention and fix the problems once and for all.

This will be your first visit with the provider you are seeing today, as you've just recently moved to this city to begin your new job. Your two sons (ages four and five) live out-of-state with their mother. You are now divorced, as you noted in the section on "Marital Status" on your intake form.

You are somewhat shy, and it takes you a while to warm up to people. You believe that the provider has all the necessary information on the intake form to treat your flu symptoms. While you'll be willing to reveal other private information about yourself to the new provider, it's not your style to blurt out information unless you're asked. If you feel comfortable and are asked the right questions, you will answer honestly.

What the provider may not know about you from your medical history form is that, after being married for six years, you realized that you are gay. You had inklings of this as a child and during your adolescence, but you suppressed these feelings for fear of upsetting your parents. During your marriage, you engaged in a few relationships with male partners and realized the truth about yourself. When you admitted this to your wife, she divorced you shortly thereafter.

Although you have lived most of your life in the USA, your early childhood was spent in Japan where your father was stationed in the military. Some of the traditions from the Japanese culture have stayed with you; for example, you do not usually say "no" when you disagree with providers, and you tend to nod your head even when you mean "no." As you learned from many of the elders in your schools, direct eye contact is considered disrespectful, particularly when talking with persons older than you. Maintaining a respectful physical space is also important.

Another thing that the provider does not know about you is that although you now practice Christianity, you were educated in a Buddhist elementary school. This has influenced your feelings about your sexuality, and you wonder if this is why you denied it for so long. Although the Buddha did not leave any teachings on homosexuality or

homosexual behavior, the monks in your school often expressed anti-gay sentiments and frequently referred to homosexuality as "sexual misconduct."

Except for the men you've met in gay social clubs, most people you've met in this city do not know about your sexual orientation, certainly not the people at work. When you tell them that you have two sons, they simply assume that you are heterosexual.

## Training Tool #80

### ROLE PLAY: INVISIBLE DIFFERENCES

CONFIDENTIAL INSTRUCTIONS

**Provider**

You will see a new patient today, which you see from the intake form is a 27-year-old Caucasian male who has recently moved to your community from another State. As noted on the section regarding marital status, you see that he is divorced and has two children. The reason for his visit is listed as "flu-like symptoms," which have lasted for approximately three weeks.

Other than what you see on the form, you know very little about this patient. To develop a good, trusting relationship and to try to learn as much as you can about this patient, you will use one of the mnemonics you were reminded of in a recent continuing education course: BATHE, LEARN, or ETHNIC.

How you enjoy seeing new patients! Not only is the influx of new patients important to your growing practice, you relish the opportunity to start with a "blank canvas" and learn as much about each patient as you can. Based on what you can tell from the patient's history, this patient is a lot like you: young, energetic, and a divorced parent of young children.

You have just been informed that the patient is ready for the exam. It's time to learn more.

## Training Tool #80

### ROLE PLAY: INVISIBLE DIFFERENCES
DISCUSSION QUESTIONS

1 Which mnemonic did the provider use for this patient visit? How well did it work in terms of learning more about his/her new patient?
2 Did the provider uncover information about the patient's intercultural background? Sexuality? Religious beliefs? If so, which parts of the mnemonic helped you most to obtain this information?
3 If this were a real-life situation, would you have looked for "invisible differences" such as cultural background, religion, and sexual orientation? Please explain.
4 Was the provider culturally sensitive during this visit – even before learning more about the patient? What improvements would you suggest?
5 How, if at all, would the provider handle the interview differently if the patient was lesbian or transgender rather than gay?
6 Did the provider avoid using the word "gay" unless that term was first used by the patient? Why is that important?
7 How did the provider deal with the patient's reticence to discuss his private life?
8 Did the discussion about the patient's flu-like symptoms take a different direction after the provider learned of the patient's sexual orientation? Why or why not?
9 How did the information about the patient's religious and cultural background aid in the interview?
10 What did this exercise teach you about cultural sensitivity when a patient's cultural, sexual, and religious differences are not obvious?

# Communicating for coordination and consistency

## Training Tool #81

**Mitigating the "Them–Us Syndrome" through higher levels of coordination**

# An interesting paradox

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Coordination/consistency

**OBJECTIVE:**

➥ to show how improved coordination can maximize existing interdependencies in health care organizations.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Begin with a brief discussion on the traditional interdependencies among personnel in health care organizations: with colleagues, persons from other disciplines and professions, health care teams, departments, etc.

Then point out that there is an interesting paradox: while health care professionals are highly interdependent on one another to provide quality patient care and services, there are strong internal pressures to identify and these stay contained within one's own profession, discipline, or area. This creates a force for competition that is sometimes referred to as the "Them–Us Syndrome" – one specialty versus another, nurses versus doctors, the medical staff versus administration, department versus department, and so on. Then ask the following questions.

**DEBRIEFING:**

1 Do you agree that there is too much "Them-Us" in health care? If so, how does that affect health professionals' ability to coordinate tasks and activities when one or more professions or disciplines are involved?
2 Which professions/disciplines within our organization should be coordinating activities to a greater degree? What tasks are involved?
3 What are the obstacles to higher levels of coordination between those groups? Are the factors psychological, policy-driven – or what? (Responses could include: pressure from one's peers to keep information from others; the sense of ownership of certain tasks/activities; getting credit/recognition/funding; status concerns; insufficient incentives for teamwork; etc.)

4 What are the benefits of higher levels of coordination? (Likely responses include: more efficient use of resources; saving time; avoiding unnecessary redundancies; and better interprofessional relationships.)

## Training Tool #82

**Developing a process for improving coordination in a medical practice**

# Enhancing coordination

**TYPE:** Flow sheet and group discussion

**ESTIMATED TRAINING TIME:** 90 minutes

**THEME:** Coordination/consistency

**OBJECTIVES:**

- to map out processes that better promote coordination and consistency within a health care organization;
- to understand the ongoing need to create greater efficiencies.

**MATERIALS NEEDED:** Sheet of butcher block paper or flip chart paper, color markers

**PROCEDURE:**

First, ask the group to identify a particular process that requires greater coordination in your practice/organization. (These might include patient arrivals, referral arrangements, communication between your practice and other settings, etc.). Be sure to identify the events that signify the beginning and ending of the process; for example, the process for admitting patients to a hospital might begin with the time the patient walks in the door to the time that the patient is placed in a bed.

When the group has decided on a problem area and the time frame, place a large sheet of butcher block paper or a flip chart page on a table in the middle of the room. Tell the group that they will be asked to work together to draw a flow chart of all steps required for the selected process from beginning to end.

Tips for developing your flow chart include the following:

- Draw boxes to indicate each step of the process, depicting the locations of each. Write in the box what the step entails and which individuals or departments are responsible for the completion of each task.
- Draw arrows to point the way from one step to another.
- Be sure to indicate the steps that must be taken by each person involved in the process. For example, a patient's responsibilities would include filling out intake forms and providing insurance information, while staff responsibilities would include entering the information into the computer, providing HIPAA forms, etc.

Allow approximately 20 minutes for the group to draw the flow chart, showing the process as it is now. Then announce that the group will have another 40 minutes to make suggested

revisions to improve the current process by showing which steps can be combined, changed, or eliminated. If time permits, ask the group to review the chart once again, first from the perspective of the health organization's personnel, and then from the perspective of patients, family members, and others.

**DEBRIEFING:**

In the remaining 20 minutes, discuss the following questions:

1 How would the suggested changes contribute to greater coordination of care and/or services?
2 How much time do you estimate that your suggested changes would save for providers and staff members? For patients and/others?
3 Why do you believe the changes you suggested for this process are necessary? Did we outgrow old policies or procedures due to changes in the patient population, available technologies, or other factors? Please explain.
4 Did you take into account that some redundancies may be useful? If so, which? In what ways?
5 Would new layers of problems be created by implementing the new consolidated process? If so, what can be done to avoid those problems?
6 What costs, if any, would be involved if these changes are implemented?
7 Would some personnel find it difficult to discard old ways of doing things in favor of the new processes? If so, what would make the transition easier for them?

## Training Tool #83

**Essentials for communication when making or receiving referrals**

# Refining referrals

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Coordination/consistency, confidentiality/privacy

**OBJECTIVES:**

- to describe ways to improve the exchange of information and feedback when making and receiving referrals;
- to show that referrals require a high level of communication, coordination, and follow-up.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Tell participants that two medical groups are developing a new referral relationship. One is a group of primary care physicians, and the other is a subspecialty group. They will soon be meeting to discuss their mutual expectations for making and receiving referrals. Note that you will ask them a series of questions about the types of things that should be discussed during this meeting.

**DEBRIEFING:**

1 What specific questions should the two groups discuss about the process for making a referral?

The two groups should exchange information about the types of problems/conditions that should be referred, the types of information desired, how to send it, how to clarify information if there are questions, and how to follow up. For example:

**Medical problems**

- What types of problems/conditions does your practice handle?
- Which do you not handle?

**Information**

- What types of information do you expect from us?
- What level of detail do you prefer?
- Is it desirable to have initial telephone consultations to discuss how each referral will be managed?

**Communication**

- What format should we use for sending referral requests?
- Do you require typed or printed notes? Computerized referral forms?
- What communication methods are preferred: telephone, mail, email, fax, delivery service?
- How can we best handle emergency contacts?
- What precautions can both groups take to ensure the confidentiality/privacy of patient information when transferring information?

**Feedback**

- What are the referral physician's expectations for timely reports?
- What should be the format of those reports?
- How should information about patient feedback be shared about their satisfaction with the referral and the quality of care/service they received?

2 Now let's talk about potential problems in the referral relationship. Please address the following:

- What should happen if the referral physician does not send reports back to the primary care providers on a timely basis?
- Under what circumstances might it be desirable to have face-to-face meetings?
- What other problems in our relationship are likely to arise, and how can we best handle them?

## Training Tool #84

**A nurse gives suboptimal instructions to her replacement during a shift change**

# The shift change

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 45 minutes

**THEMES:** Coordination/consistency, prevent/reduce medical errors

**OBJECTIVES:**

- to show the importance of shift change reports to patient safety and continuity of care;
- to identify ways to improve the exchange of information during shift changes.

**MATERIALS NEEDED:** A copy of the case study for all participants; flip chart (optional)

**PROCEDURE:**

Distribute the case study to all participants, give them a few minutes to read it, and then ask the following questions.

**DEBRIEFING:**

1 What are the problems with this handoff? (Likely responses include: Hilda's late arrival, which contributed to the rushed exchange of information; Paula's attempt to provide information only in writing rather than waiting to meet with Hilda in person; discussing other patients' conditions in the presence of a patient; Paula's interpretation of Hilda's request for more information as a personal criticism; Paula leaving an undone task to her successor; and not taking sufficient time to discuss all essential details.)
2 How might these problems affect Hilda's ability to provide seamless care after taking over the shift?
3 Since providers have their own ways of prioritizing and communicating information to their replacements, what would be the value of standardizing changeover reports?
4 While health professionals with large patient assignments may provide taped or written reports to their successors during shift changeovers, why do you think experts believe that these methods should still be accompanied by face-to-face updates? Under what conditions, if any, is it acceptable to leave a shift without personally visiting with your replacement?
5 Why do you think some health professionals prefer to conduct walking rounds with their replacements for shift-change reports? For those who do walking rounds, should information be explained in front of the patient? Why or why not?
6 How do you think new communication technologies (e.g. personal digital assistants,

or PDAs) can be used to enhance shift change reports? Can new technologies replace face-to-face interactions? Why or why not?

7 When did Paula's shift end and Hilda's shift begin? Which individual was responsible for reapplying Mr. Temple's bandage? Would your response be different if Paula left a patient who was coding? Please explain.

8 Was Tom out of line to overhear and try to comment during Paula's shift change report? What are the benefits of overhearing others' reports and identifying potential problems?

9 Should Hilda have insisted that Paula take more time on the changeover, even though she was late to work and Paula was anxious to leave?

10 What should be on any provider's "to-do" list for shift changeovers? (Answers may include: reading back information to prevent misunderstandings; allowing time to ask and answer questions; discussing items from a checklist for each patient to ensure that all aspects of care are covered, e.g. medical, pharmacological, emotional/psychological, rehabilitative, and nutritional; and following standardized sign-out procedures.)

11 What did this case study illustrate about the relationship between the quality of shift changeovers and the continuity of care? Patient safety?

12 To what extent do these lessons apply to physicians and others making shift changes?

## Training Tool #84

### CASE STUDY: THE SHIFT CHANGE

After a 10-hour shift at Major Medical Center, Paula Passer, RN, was exhausted and anxious to go home. It had been an especially difficult day in the Cardiac Care Unit, as two patients had major post-surgery complications. A 76-year-old woman developed pulmonary emboli after bypass surgery along with a troublesome case of delirium. Another patient, a 58-year-old man, developed a severe infection on his right leg following angioplasty. Down the hall, an anxious 49-year-old man whose own blood was not stored in advance, had refused a blood transfusion for fear of getting AIDS.

When Paula's replacement, Hilda Handley, RN, arrived only 10 minutes before the shift change, Tom Middleton, LPN called her over. He didn't feel it was his position to tell her that, according to policy, she was 20 minutes late.

"Hilda! You must have been stuck in traffic. I have something for you that Paula said to give you." He handed her the notes that Paula had written to update her successor on the conditions of her patients. Hilda quickly scanned the notes.

"Where is Paula?" Hilda asked. When Tom said she was in room 123, changing the dressing on Mr. Temple's leg, Hilda went to the room immediately.

Hilda said hello to Mr. Temple, who looked quite uncomfortable, and waved the papers she had just been handed close to Paula's face.

"Tom just gave me these notes you wrote," Hilda said. "Weren't you going to find me to give me these in person?"

"I didn't think there would be time," Paula replied hurriedly. "I've been here for 10 hours and I've got to get home to collapse. Everything you need to know is in the notes."

"Not so fast, Paula," Hilda said. "I need to ask about Mrs. Beasley, our patient who is suffering delirium after bypass surgery. Your notes say that she's not as alert today, and I need to get a clearer description of her current status. What else can you tell me?"

Paula responded in somewhat greater detail, but in a curt, strained voice; she was quite certain that Hilda's question was a thinly-veiled criticism. Paula continued working on Mr. Temple's leg while answering more of Hilda's questions about other patients on the floor.

While they were talking, they barely noticed Tom entering and leaving the room, handling various tasks. At one point, Tom heard Paula give information that was so truncated, he was certain that Hilda wouldn't understand some of the issues regarding Mrs. Beasley's delirium and emboli.

"Excuse me," Tom interjected. "I just overheard what you were saying, and I don't think . . ."

"Tom, we're doing a shift change!" Paula exclaimed, as she wrapped the bandage around Mr. Temple's leg. "If you get involved in this, I'll never be able to leave!"

"OW!" Mr. Temple cried. "That bandage is too tight!"

Paula started to undo the bandage when she noticed the clock. "That's the end of my shift," Paula said. "I'm out of here! You finish this up, okay Hilda?" With bandages strewn about, Paula left the room.

Paula could barely hear Hilda yelling after her, "But I have one more question!"

## Training Tool #85

**The dangers of not communicating with previous providers**

# Past and present

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Coordination/consistency, prevent/reduce medical errors

**OBJECTIVE:**

➥ to raise awareness about the need to obtain medical records for all new patients from their previous providers.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Distribute the case study and ask participants to form small groups to identify the major lessons from this case about medical history taking, continuity of care, patient safety, and communication between providers. After 15 minutes, bring participants back together for an all-group discussion.

**DEBRIEFING:**

1 While hindsight is 20–0, what were the main oversights by Dr. Newton that led to Harold's demise?
2 What are the benefits of obtaining new patients' medical records from their previous physicians or other providers? Why do you think some don't request these records?
3 Since not every possible symptom can be listed on medical history forms, how can physicians or other providers learn about relevant symptoms that patients don't mark down?
4 Although many physicians do not order chest X-rays before trying more conservative approaches first, what could Dr. Newton have done differently that would have given him clues about the severity of Harold's medical problem?

A special thanks to Thomas H. Ryerson, Esq., a leading medical malpractice defense attorney and partner in Clausen Miller PC in Chicago, Illinois, for providing the concept for this exercise.

## Training Tool #85

### CASE STUDY: PAST AND PRESENT

When Harold Hacker, a 49-year-old truck driver, learned that his employer had decided to change managed care companies to reduce the costs of health insurance, he was dismayed to learn that his long-time primary care physician, Dr. Oldham, was not on the new company's list of preferred providers. In order to receive insurance coverage, he would have to find a new doctor. With the worsening of a nagging cough that had plagued him for the past three weeks, he needed one right away.

After getting several recommendations from friends and family, Harold made an appointment with Dr. Ned Newton, whose office was not far from Harold's home. Along with numerous other forms given to new patients, he filled out his medical history form, carefully checking the boxes that applied. Are you a smoker? *Yes*. How much? *More than two packs per day*. How long have you smoked? *More than 25 years*. Harold continued checking boxes, yes or no, until the form was completed, citing "bad cough" as the reason for his first visit.

Dr. Newton gave Harold a basic physical exam, asked several more questions that occurred to him after reading Harold's form, and prescribed a popular allergy medication. A month later, Harold returned to Dr. Newton's office to report that the meds weren't working; his cough simply wouldn't go away. Thinking that his patient's upper respiratory infection had turned bacterial, Dr. Newton wrote a prescription for an antibiotic. After another long road trip, Harold returned, noting that this medication didn't work either. Over the ensuing months, Dr. Newton tried another antibiotic, then another.

More than six months had passed, and Harold wasn't getting any better, so Dr. Newton ordered a chest X-ray, blood tests – the works. It was then that Dr. Newton had discovered that Harold had lung cancer. Dr. Newton referred his patient immediately to an oncology practice, where they soon learned that Harold had had hemoptysis since his coughing began; a fact unbeknownst to Dr. Newton. Less than three months later, Harold Hacker passed away.

Dr. Newton reviewed Harold Hacker's intake forms, trying to ascertain why he wasn't aware that Harold had been coughing up blood since the onset of symptoms. There was no mention of this problem on Harold's forms; it wasn't an option on the checklist. Nor did Harold mention this symptom during any of their visits.

Across town, Dr. Oldham was saddened and surprised to read in the morning paper about the passing of Harold Hacker, his former patient. He wondered why Dr. Newton didn't request Harold's medical records; he would have seen "hemoptysis" listed there on his last visit with Dr. Oldham, just before Harold changed doctors.

## Training Tool #86

**Changes in a patient's consent form aren't passed along to the new shift**

# Bewitching encounter

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Coordination/consistency, prevent/reduce medical errors, intercultural communication

**OBJECTIVES:**

- to demonstrate the need for interdisciplinary communication and coordination in all aspects of a patient's care;
- to identify ways to ensure that promises are kept regarding patients' special requests, preferences, or needs.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Distribute copies of the case study and divide participants into small groups of four to five people each. Ask each group to spend 15 minutes discussing the case to determine the point(s) where communication and coordination broke down. In the remaining time, conduct an all-group discussion.

**DEBRIEFING:**

1 In your group discussions, what did you find were the point(s) where coordination broke down? Was it only after Samantha was admitted to the hospital, or did lapses occur before then?
2 Because Samantha had carefully selected a doctor who agreed to adhere to her treatment preferences, what, if anything, could Dr. Bombay have done to communicate her needs with hospital staff beforehand?
3 During Samantha's prenatal visits, should Dr. Bombay also have talked with her about how to handle medical emergencies, given her preferences for noninvasive and natural procedures?
4 Could the doctor have identified Samantha's needs and concerns by asking questions prior to her delivery? If so, what questions might have uncovered her concerns with the consent form?
5 What principles from intercultural communication might have applied to this case?

A special thanks to Thomas H. Ryerson, Esq., a leading medical malpractice defense attorney and partner in Clausen Miller PC in Chicago, Illinois, for providing the concept for this exercise.

## Training Tool #86

### CASE STUDY: BEWITCHING ENCOUNTER

By the time Samantha Stevens went into labor for the delivery of her first child, she felt confident that she had done everything possible to ensure that the birthing process would be in accordance with her wishes. After interviewing several obstetricians-gynecologists, she was delighted to find Dr. Bombay, who readily agreed to deliver the child in accordance with Samantha's faith. As she explained to the doctor, she was a devotee of the Wiccan religion and referred to herself as a witch.

To ensure her baby's health, Samantha performed numerous Wiccan rituals throughout her pregnancy, but none of these were intended to replace the need for medical care. As Samantha explained to Dr. Bombay, witches believe that rituals are a vital adjunct to medical care, not a replacement. They also believe strongly that natural, holistic care is always preferable to invasive types of interventions. "Seeking care within Nature" is, after all, one of the key Wiccan principles.

When Samantha went into labor, she settled into a bed in one of the hospital's modern maternity/birthing rooms with husband Darrin at her side. An aide from the obstetrics-gynecology administrative office brought Samantha a consent form to sign, and waited eagerly while Samantha read it. The aide could see that Samantha was visibly upset.

"No! No! This isn't what Dr. Bombay agreed to," Samantha said, taking a thick black marker from her purse and drawing through the procedures that were contrary to her Wiccan beliefs. After drawing thick lines through "Caesarian section," "forceps delivery," "episiotomy," and a few other items, she smiled and signed the form.

By the time Samantha was sufficiently dilated and ready for childbirth, the shift had changed and a new set of nurses had gathered around Samantha's delivery bed. Dr. Bombay gleamed as he entered the room. "You'll never forget this day," he said.

During the delivery, Samantha screamed in pain.

"Samantha, I'm going to need to do an episiotomy. The baby is struggling to get out . . . there just isn't enough room." As he was talking, Dr. Bombay had already made a cut with his surgical knife.

"What are you DOING?" Samantha cried. "Don't you remember that I'm Wiccan? Didn't you see the changes I made on the consent form? I said NO EPISIOTOMY!!!"

Dr. Bombay turned around to the nursing staff, and one nurse shrugged her shoulders. Another said, "We never saw the form either. It must not have gotten to us after the shift change."

**The importance of communicating fully with consulting physicians**

## Training Tool #87

# Dropping the ball

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Coordination/consistency, prevent/reduce medical errors

**OBJECTIVE:**

➥ to show the importance of coordinating all aspects of a patient's care – including follow-up – when two or more providers are involved.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Distribute copies of the case study and divide participants into small groups of four to five people each. Ask each group to spend 15 minutes discussing the case to determine the point(s) where communication and coordination broke down. In the remaining time, conduct an all-group discussion.

**DEBRIEFING:**

1 What happened – or did not happen – that caused Drs. Kuloss and Sharp to develop misunderstandings regarding which physician was responsible for Patricia's follow-up care?
2 Should one physician have handled all aspects of Patricia's follow-up, or should they have taken responsibility for certain aspects; that is, Dr. Sharp would handle the surgical follow-up, while Dr. Kuloss would handle the medical follow-up?
3 When Dr. Sharp sent copies of the lab reports to Dr. Kuloss, why was it not clear that he sent the reports for action and not just information?
4 Is it usual for physicians to avoid "communicating the obvious" for fear of insulting the other or stepping on another doctor's turf? What are the dangers of these tendencies?
5 What did this exercise teach you about communicating with consulting physicians? What were the lessons about the coordination of care?

A special thanks to Thomas H. Ryerson, Esq., a leading medical malpractice defense attorney and partner in Clausen Miller PC in Chicago, Illinois, for providing the concept for this exercise.

## Training Tool #87

### CASE STUDY: DROPPING THE BALL

Patricia Payne, a 32-year-old school teacher with two children, had no time for the excruciating headache that seemed to come out of nowhere. In addition to her family and career, she was a well-known community activist and had numerous evening meetings to attend. After three days, her husband, Paul, grew quite concerned that she was not only missing work and meetings, but finding it difficult to get the kids off to school, and insisted that she see her primary care physician.

Dr. Mattie Kuloss was alarmed, not only by the severity of Patricia's headaches, but also because she saw in her charts that Patricia's mother had died of a brain aneurism. She also knew that women were more likely than men to develop this problem. Taking no chances, she made immediate arrangements to send Patricia to the hospital.

Soon after Patricia's admission, a neurosurgical team, led by Dr. Stephen Sharp, conducted a 4.5-hour surgery on the left side of Patricia's brain to correct an aneurism that was discovered in a CT scan and MRI. Following surgery, Dr. Sharp prescribed phenytoin, an anti-epileptic drug to control seizures.

Patricia was on top of the world, relieved and grateful for the care she received. She profusely thanked Dr. Kuloss for having her admitted to the hospital so quickly, and expressed her deep appreciation to Dr. Sharp for saving her life in the surgery. As instructed by Dr. Sharp, Patricia continued to take the phenytoin during her recovery at home.

Dr. Sharp continued to monitor Patricia's healing, particularly to ensure that the incision area was free of infections, and sent regular reports to Dr. Kuloss, but without additional notations. In one of the lab reports, Dr. Kuloss noticed that Patricia's blood platelet count was dropping quite a bit, but didn't want to insult Dr. Sharp by pointing out the obvious.

Days later, with the continued decrease in Patricia's platelet count, Dr. Kuloss realized that this was a reaction to her post-surgical medication and finally decided to discuss the matter with Dr. Sharp.

"You're her primary care physician," Dr. Sharp said. "She was already at home. Why didn't you take care of this?"

"You were the one who was monitoring her, post-surgery, and you were the one who prescribed the medication," Dr. Kuloss replied. "I thought you would handle it."

By the time Dr. Sharp told Patricia to discontinue the phenytoin, the area of the aneurism repair ruptured, causing intracranial bleeding and swelling. This resulted in brain damage, manifested as aphasia. She would never walk or talk again.

An administrator proposes weekly meetings with doctors

## Training Tool #88

# Meeting madness

**TYPE:** Role play – physician and office manager

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Coordination/consistency

**OBJECTIVES:**

- to show how coordination of activities can become competitive due to lack of clarity regarding roles, time issues, and other matters;
- to demonstrate the importance of coordinating activities by taking each person's interests and needs into account.

**MATERIALS NEEDED:** Copies of the two roles for each dyad

**PROCEDURE:**

Ask all participants to identify a partner. If there are an uneven number of participants, have the extra person either serve as observer or play the role of another physician. Distribute the confidential instructions so that each person in the dyads is playing an opposing role.

**DEBRIEFING:**

1 Could activities be coordinated successfully without a face-to-face meeting? If so, how?
2 What are the main issues in this dispute?
3 In your role plays, how did you resolve the issue of time? Was the administrator unreasonable in requesting a weekly meeting, considering the doctors' time constraints? Was the use of the administrator's time also considered?
4 Which party is responsible for the coordination of activities?
5 Did you resolve the dispute in a way that met the needs of both parties? If so, how?

## Training Tool #88

### ROLE PLAY: MEETING MADNESS
CONFIDENTIAL INSTRUCTIONS

**Physician – Ian Nuff, MD**

You have been in practice at a rural health clinic for eight years, and the office administrator has been employed there for less than one year. You sometimes wish that this particular person hadn't been hired.

What's your beef? The administrator seems to take great pride in communicating regularly with everyone in the clinic, but you think things have gone too far. Just recently, the administrator asked you and the two other physicians to come in earlier on Monday mornings (at 7:00 a.m.) for a one-hour meeting to coordinate the week's activities. You find this proposal quite unacceptable, for the following reasons.

- You have an extensive workload and don't want to add more hours to your already full schedule. Meeting four more hours each month? Ridiculous. Even two extra hours would be a waste.
- You have small children at home and prefer not to get up even earlier on Monday mornings than you already do.
- You find meetings to be unproductive and a colossal waste of time. Besides, you already attend monthly all-staff meetings. Enough is enough!
- The way things are coordinated now – with the administrator talking individually to you and the other doctors – helps you to save time. So what if the administrator complains about having to repeat the same issues three times in separate meetings with the three doctors? Your time is more valuable.
- You believe that physicians should have meetings with the administrator only when problems arise. Or, as you've suggested to the administrator, issues involving the physicians should be sent to the three of you via email.
- You believe coordination of office activities is the administrator's job. Because you and the other doctors are not shy about making your opinions known, you think that the meetings will only be for the administrator's benefit.

Because the other two physicians don't feel strongly about weekly meetings either way, they have agreed to go along with whatever you and the administrator work out. The meeting is about to begin.

## Training Tool #88

### ROLE PLAY: MEETING MADNESS
CONFIDENTIAL INSTRUCTIONS

**Office Administrator**

You have been employed at your rural health clinic for less than a year, and things aren't going as smoothly as you'd hoped. Because it seems you're continually handling problems that have resulted from a lack of coordination, you'd like to have more meetings. Specifically, you have proposed holding meetings with the three physicians on Monday mornings at 7:00 a.m. for the purpose of coordinating the week's activities.

One of the main reasons you'd like to have a meeting with the doctors each week is because when there's a problem, you have to run to each doctor to poll them about what to do. This takes you a great deal of time, which the doctors don't seem to care about. By having everyone meet at once, you feel that you will be able to save time and be more proactive about office problems rather than simply reactive.

You can't believe you're getting so much resistance to this proposal from one of the physicians, Dr. Ian Nuff. The other two doctors don't seem to care either way, but Dr. Nuff adamantly opposes additional meetings, particularly on Monday mornings. You believe the practice will run much more smoothly when everyone is on the "same page" at the beginning of the week.

In previous conversations, Dr. Nuff gave several reasons for not wanting to meet each week: not wanting to put in more hours; not wanting to get up earlier; and seeing meetings as unproductive and a "colossal waste of time." Dr. Nuff suggests maintaining the status quo – having you visit with each doctor on each issue when you can catch them in the hallways – or by sending emails.

You believe there is no replacement for face-to-face communication and that weekly meetings are not just best for you, but for everyone, because the doctors need to discuss issues together rather than give their opinions independently. Dr. Nuff is coming to your office to discuss this matter with you now.

# Communicating to prevent and reduce medical errors

## Training Tool #89

**Identifying the root causes of medical errors and establishing a culture of safety**

# Root causes of medical errors

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Prevent/reduce medical errors

**OBJECTIVE:**

➥ to raise awareness of the root causes of medical errors and the need to establish a culture of safety.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Before the session, conduct research and develop a brief lecture about preventing and avoiding medical errors, noting that the root causes of errors are usually attributable to systems problems rather than people problems. Then ask the group to address the following questions.

**DEBRIEFING:**

1 Since research indicates that medical errors are normally attributable to systems problems rather than people problems, why do you think people still tend to look for blame in individuals? What are the effects of blaming individuals?
2 If a systems problem is determined to be the root cause of a medical error, to what extent are involved parties personally accountable?
3 How can we emphasize coaching and education for persons involved in medical errors in a health care environment that is built around perfection and discipline?
4 What are the barriers to creating a culture of safety in health care organizations?
5 How can we overcome those barriers?

**Identifying and dealing with emotions after making a medical error**

## Training Tool #90

# Coping skills

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEME:** Prevent/reduce medical errors

**OBJECTIVES:**

- to identify the emotions that result from making errors;
- to underscore the importance of learning from one's mistakes.

**MATERIALS NEEDED:** None

**PROCEDURE:**

Ask the group to identify emotions that health care professionals experience upon realizing that they have made a medical error. (Responses are likely to include regret, shame, embarrassment, and loss of face.) Ask: "When health care professionals have committed an error, how do they normally cope with these emotions in order to move on? How should they?"

One likely response is that many health professionals do not openly discuss their emotions after committing an error. When this is mentioned, point out that bottling up one's feelings not only creates more stress, but also causes those involved to miss valuable opportunities to discuss what happened and learn from their experiences.

**DEBRIEFING:**

Point out that one of the best ways for health care professionals to learn from their mistakes is to discuss them with their colleagues, not only to hear their colleagues' perspectives, but to learn from others' experiences. From these discussions, they are likely to learn that (i) they need to forgive themselves, learn from their mistakes, and move on; (ii) many medical errors are signals of procedural breakdowns that need to be fixed; and (iii) that they are human – and that their peers and educators have experienced similar problems too.

Noting that there will be no retribution for any admissions in the ensuing discussion, ask these questions:

1 What was the nature of your last near-miss?
2 Did you tell anyone about it?
3 How did you feel?
4 What would you do if you saw someone covering up a mistake?

## Training Tool #91

**A nurse tells a family about a slip-up she observed during a bypass procedure**

# Friend of the family

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Prevent/reduce medical errors

**OBJECTIVES:**

- to show the need for health professionals to determine who should/should not convey information to family members and patients;
- to determine how and how much to disclose to patients regarding medical errors.

**MATERIALS NEEDED:** A copy of the case study for all participants

**PROCEDURE:**

Distribute the case study to all participants. After giving them a few minutes to read it, point out that the case involves how and how much to disclose to family members about medical errors; if a physician or another provider has a right to keep certain information from being disclosed; and which person(s) are responsible for revealing information. Note that participants will have 15 minutes to discuss the case, followed by an all-group discussion.

**DEBRIEFING:**

1 Should Teresa have told the family what she observed in the OR? Did it matter that she had a close relationship with the family? Why or why not?
2 Would Dr. Blade be justified in *not* telling the family about the error? Does it matter that he fixed the problem successfully? Please explain.
3 If Dr. Blade decided not to tell the family about the error – but Teresa believed that they should know – would it then be acceptable for Teresa to convey this information to Betsy and her kids?
4 When one isn't sure whether it's appropriate to convey certain information or not (in this case, about a medical error that was fixed), is it better to err on the side of over-communication or under-communication? Please explain your reasoning.

## Training Tool #91

### CASE STUDY: FRIEND OF THE FAMILY

Teresa Teller, RN, has been a nurse in the cardiology department at City View Medical Center for the past eight years and, in all this time, she can't remember feeling closer to any patient's family than she has with the Bridges. Bud Bridges is a charming 58-year-old man who has been hospitalized on numerous times for various heart problems. Over the years, Teresa has gotten to know him, his wife, Betsy and their two adult children quite well. After Bud's last hospital stay for an angioplasty, the family sent her a beautiful bouquet of roses to thank her for her excellent care.

Shortly after Teresa found out that Bud would be back in the hospital for heart bypass surgery, Betsy Bridges called and asked if she would be able to be Bud's nurse again. Because Teresa has now have been assigned supervisory responsibilities, she explained that she would not be able to provide his pre- or post-surgical care, but that she would keep close tabs on Bud and be as available to Bud and the family as possible.

"I feel so close to you all," Teresa told Betsy, "And although it's highly unusual for him to allow me to do it, I'd even be happy to ask Dr. Blade if I can be present to observe the surgery." Betsy urged her to do that.

Because Teresa has enjoyed an excellent relationship with Dr. Blade, the medical center's chief cardiothoracic surgeon, he approved her request to observe the bypass surgery – especially when she explained her close relationship with the Bridges. Teresa hadn't seen many surgeries at such close range and found the experience fascinating. When the surgery was nearly over, she came to the family waiting area and spoke to Betsy and her kids.

"Everything went fine!" Teresa exclaimed to the Bridges family. "It was so exciting to see Dr. Blade in action. He's the best surgeon around! And Bud is going to be fine!"

Betsy and the kids breathed a sigh of relief. "The surgery took quite a bit longer than expected," Teresa continued. "There was a minor crisis along the way. Dr. Blade's scalpel slipped and he nicked a part of the aorta so he needed to repair it. These things happen, but Dr. Blade fixed the problem and Bud will be fine."

Then Teresa paused, just then realizing that perhaps this information wasn't hers to tell. "Umm, please, Betsy, you probably shouldn't mention to Dr. Blade that I told you this. Let him be the one to tell you."

Apparently, Betsy couldn't keep herself from discussing this matter with Dr. Blade. The next time Teresa saw Dr. Blade, his face was flushed with rage and he brought her to a private area to talk.

"Teresa, what is the matter with you? I just heard from Mrs. Bridges that you

told her what happened in the OR. You have worried her unnecessarily, and it was none of your business to tell the family anything about the surgery. You were just an observer! I am extremely angry with you right now."

**A selection of cases that explore ways to reduce and prevent medical errors**

## Training Tool #92–5

# Case studies on avoiding/preventing medical errors

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 45 minutes (two cases)

**THEME:** Prevent/reduce medical errors

**OBJECTIVES:**

- to dissect the causes of problems leading to errors in various situations;
- to identify ways to address errors and keep them from happening in the future.

**MATERIALS NEEDED:** A copy of two case studies for all participants

**PROCEDURE:**

Select two cases from the following options.

- **Mum's the word** – A doctor and nurse have differences about whether orders should be repeated.
- **Who's on first?** – Reviewing the wrong medical record leads to a medication error.
- **Is no news good news?** – A patient's problem worsens after not receiving lab results.
- **Two birds, one stone** – A dentist forgets to do one of two procedures while a patient is anesthetized.

Divide participants into subgroups of four to five persons each, and assign each group to analyze and make recommendations on the two selected cases. Designate one individual from each group to serve as recorder and report on the group's findings at the conclusion of the exercise. Use the questions following each exercise to guide the group's discussion.

**DEBRIEFING:**

After a report from each group on their analysis of the case studies, facilitate an all-group discussion with the following additional questions:

1 What common themes emerged in the group reports about avoiding and reducing medical errors?
2 Is it likely that the strategies your group suggested would be implemented in real-life situations? Why or why not?

3 Have you had experiences similar to those cited in these cases? If so, how did you handle them? What would you do differently now?
4 What are the major take-home lessons from our discussions of these case studies about preventing or reducing medical errors?

## Training Tool #92

### CASE STUDY: MUM'S THE WORD

When Mindy Meek, RN, began work at the Creekside Family Care Center three months ago, she immediately realized that she was cut from an entirely different mold than her boss, Dr. Barbara Barker. Whereas Ms. Meek is soft-spoken, calm, and communicative, Dr. Barker is abrasive, stressed, and short-tempered. On several occasions, when Ms. Meek has asked for clarification or repeated back orders to ensure accuracy, Dr. Barker typically responded, "Just listen more carefully and you'll get the message the first time," and "Didn't I just say that? Why are you repeating what I just said?" Tired of being rebuked, Ms. Meek hasn't asked questions or repeated orders lately and it seems that their relationship is starting to improve.

Today, Dr. Barker asked Ms. Meek to call in a prescription right away for an 88-year-old patient with Crohn's disease. Ms. Meek wonders if she heard correctly, believing that the doctor asked for more than twice the normal adult dosage. On the other hand, since the medication is relatively new on the market, she isn't quite sure.

### DISCUSSION QUESTIONS

1 What underlying reasons might be causing the doctor to feel that questions and repeated orders are unnecessary?
2 What is the responsibility of each party in this case? What forces might cause the nurse to keep quiet, even though she knows that speaking up is in the patient's best interest?
3 How can Ms. Meek address this issue without incurring Dr. Barker's wrath?
4 What must the doctor and nurse do to improve their working relationship, given their different approaches to communication?
5 What systems issues might be involved? Should other personnel be involved in this problem as well?

## Training Tool #93

### CASE STUDY: WHO'S ON FIRST?

Trista Thompson, PA, takes pride in being a perfectionist. Well known throughout the Staywell Community Health Center for checking and rechecking her work, she has little patience for those who don't share her passion for precision. Today, Trista learned that one of her patients, Ryan Runyan, age 70, has been hospitalized for seizures after taking medications that she recently prescribed. Ms. Thompson was mortified. As she investigated, she discovered that she had been given the medical record for Ryan's son, Ryan Runyan II, age 40, by mistake. If she had had the right record, she would have realized that Ryan Runyan, Sr. had reduced liver function, which would have caused her to adjust the dosage due to the role of that organ in metabolizing drugs. "I want to know who is responsible for this," Ms. Thompson proclaimed. "Someone's head is going to roll."

### DISCUSSION QUESTIONS

1 Who was responsible for ensuring that Ms. Thompson had the correct medical record?
2 What systems issues are involved? What can be done about them?
3 What is the likely effect of Ms. Thompson's proclamation that "Someone's head is going to roll" on other members of the office staff? Will this draw attention to the importance of each team member's role in avoiding mistakes? Or will it have the reverse effect, causing people to hide and defend their mistakes?
4 What is a more appropriate way for Ms. Thompson to deal with this problem?
5 Should she admit the error to the hospital? To her patient? If so, what should she say and how?

## Training Tool #94

### CASE STUDY: IS NO NEWS GOOD NEWS?

At her office visit with Dr. Will Trueperson last week for her annual physical, Grace Sadler was given several blood tests and a urinalysis. Reporting that she felt "pretty good," Ms. Sadler didn't present specific symptoms other than feeling a little tired and shaky, which she quickly attributed to stress from her new job. At the end of their visit, Dr. Trueperson said, "You look like you're in good shape, Grace. We'll call you if there's any problem with your tests."

Since Ms. Sadler didn't receive a call, she assumed that there was no problem. Now, back in the office with complaints of severe back pain, nausea, vomiting, and fever, Ms. Sadler is angered to learn that her urinalysis last week revealed a mild infection, which now has become a severe kidney infection.

"If your office had called me as I was promised, I could have had this problem treated before it got worse," Ms. Sadler said.

"I'm sorry," the doctor replied, "but we have thousands of patients and sometimes get busy. If you didn't hear from us, *you* should have called."

### DISCUSSION QUESTIONS

1 Whose responsibility was it to call about the test results?
2 Since Ms. Sadler was not notified, should she have made the call herself?
3 What should Dr. Trueperson do in terms of service recovery to avoid losing this patient to another practice? Was the apology enough?
4 What underlying systems problems are likely in this case?
5 What can be done to prevent similar problems in the future?

## Training Tool #95

### CASE STUDY: TWO BIRDS, ONE STONE

Denny Mitchell is a feisty 16-year-old who isn't afraid of his classmates – in a recent fight with classmates, his front two teeth were knocked out – but he *is* afraid of dentists. As he told his mother, Mrs. Alicia Mitchell, he would only agree to have implants if he could be "totally knocked out." George Wilson, DDS, who is fully qualified to administer general anesthesia, agreed to Denny's request. Since Denny also needed to have his wisdom teeth removed, Mrs. Mitchell asked Dr. Wilson if he would do both procedures during the same visit so that Denny wouldn't have to undergo anesthesia twice, and Dr. Wilson again agreed.

The surgery was performed today. The implant surgery went extremely well, and Dr. Wilson was delighted that Denny tolerated the anesthesia so well. Only when he saw Mrs. Mitchell in the reception area did he realize that he had forgotten to remove Denny's wisdom teeth. Denny will now require a separate procedure in which he will need to be anesthetized once again.

### DISCUSSION QUESTIONS

1 How should Dr. Wilson explain to Mrs. Mitchell that, while the implants were installed quite successfully, he forgot to remove Denny's wisdom teeth during the same visit, as promised?
2 Assuming that Mrs. Mitchell is concerned with problems involving general anesthesia, how can he ease her concerns?
3 Given Denny's nervousness about dental procedures, what should Dr. Wilson say to Denny?
4 What systems problems are possibly involved in Dr. Wilson's oversight?
5 How can such problems be avoided in the future?

The dangers of specialty biases toward certain diagnoses

## Training Tool #96

# Hammer and nails

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Prevent/reduce medical errors, coordination/consistency

**OBJECTIVES:**

- to show how "hammer and nail biases" can lead to misdiagnoses, thus having a major negative impact on patient safety;
- to identify ways that providers can develop a broader perspective when exploring a patient's medical problems rather than view the problems through the lens of their specialty alone.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Ask participants to form small groups of four to six persons, distribute the case study, and give the groups 15 minutes to discuss the reasons for the delay in Sam's diagnosis. In the remaining time, call participants back together for an all-group discussion.

**DEBRIEFING:**

To begin the group discussion, explain that doctors often have a hammer-and-nail bias; that is, "if you have a hammer, everything looks like a nail." Applying this to health care, your training and experiences may cause you to look for problems or conditions that you see most frequently in your specialty. Then ask:

1 What did your groups identify as the reasons for the delay in Sam's diagnosis?
2 What are the perils of this bias?
3 How common is this bias, given that numerous professions and disciplines with their own unique knowledge base often treat the same conditions?
4 What can health professionals do to avoid the hammer-and-nail bias to ensure that they are on the correct diagnostic path?
5 Is it realistic to hope that this bias can be avoided, since there are many thousands of conditions that cause pain?

A special thanks to Thomas H. Ryerson, Esq., a leading medical malpractice defense attorney and partner in Clausen Miller PC in Chicago, Illinois, for providing the concept for this exercise.

## Training Tool #96

### CASE STUDY: HAMMER AND NAILS

On three occasions, Sam Sorenson, age 29, visited the office of his primary care physician, Dr. Carrie Fuller, to get relief for the nagging pain in his lower back. As he told Dr. Fuller, the pain isn't constant, but it seems to be worse at night and also when he plays softball with his friends on Sunday afternoons. Dr. Fuller also learned that Sam does a great deal of strenuous yard work.

After conducting a series of diagnostic tests and not finding a medical source of the problem, Dr. Fuller tried various conservative treatments, mainly through pain management and the advice to avoid physical activity. During his third visit, however, Sam reported that his back hurt more than ever and that he also had a new symptom: stiffness in the joints around his hips.

Throughout the next year, Dr. Fuller coordinated Sam's care during referrals to a series of specialists:

- a rheumatologist checked Sam for osteoporosis and spinal arthritis;
- an orthopedist looked for a ruptured disk or scoliosis;
- an anesthesiologist suggested nerve blocks;
- a physiatrist recommended physical rehabilitation and a synthetic brace to correct Sam's posture;
- a chiropractor performed spinal adjustments to remove interruptions to the flow of transmissions from Sam's nerves;
- a neurosurgeon recommended spinal cord surgery;
- a psychologist suggested weekly visits to his office for psychotherapy and coping skills;
- an alternative health center offered homeopathy, massage, energy healing, and acupuncture.

During these visits, Sam's pain worsened considerably and his movement became severely restricted. The only thing that seemed to help was morphine, but Sam worried about the long-term effects.

In sheer frustration, Dr. Fuller began pulling together all of the information and realized that a key piece of the puzzle had been missed. She asked a group of oncologists to check Sam for osteosarcoma, and they confirmed her suspicions. Sam finally had an answer, though not the one that anyone had hoped.

**A patient with acute respiratory distress is misdiagnosed due to perceptual problems**

## Training Tool #97

# Close call

**TYPE:** Case study

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Prevent/reduce medical errors

**OBJECTIVES:**

- to show how perceptual problems can lead to medical errors;
- to identify ways that perceptual problems can be avoided in order to make correct diagnoses.

**MATERIALS NEEDED:** A copy of the case study on the following page for all participants

**PROCEDURE:**

Ask participants to form small groups of four to six persons. As you distribute the case study, note that each group will have 15 minutes to discuss what might have caused the initial misdiagnosis and what could be done to avoid such problems. Bring participants back together for an all-group discussion in the remaining time.

**DEBRIEFING:**

1 What might have been going through the ER doctor's mind that caused the misdiagnosis of the patient's respiratory distress?

Likely responses may include:

- clinging to first impressions: seeing how distraught the patient was, seeing that she was on an antidepressant, learning that the respiratory problem developed while discussing her family tragedy, and limiting the interview to that line of questioning;
- jumping to conclusions: assuming too quickly that the patient's symptoms were attributable to her mental state;
- looking for a single cause: not looking further for reasons for the patient's problem after landing on a diagnosis;
- only seeking evidence that supported the doctor's initial hypothesis: not seeking out disconfirming evidence that would have challenged his hunch;
- seeing the immediate need to treat symptoms rather than seek the cause.

2 What do you think causes us to latch onto our first impressions? What causes us to only seek evidence that supports our hunches? (Explain that these perceptual problems

are normal human tendencies. Humans tend to strive for consistency by seeking congruence with previously held thoughts and seek evidence that supports those thoughts.)

3 Do you think that providers tend to seek psychiatric/psychological explanations for a patient's problem when a medical explanation is not readily apparent? If so, why might that be?

4 Since there are many occasions when a psychiatric/psychological diagnosis is correct, what can be done to test your initial hypothesis?

5 What clues could have led the ER physician to a correct diagnosis? (The fact that the patient's urinary tract infection was recent would have indicated that the patient may not have used that medication before.)

6 Since the ER doctor was able to treat the patient's symptoms successfully during the ER visit, did it matter that the diagnosis was not correct? Please explain.

7 The primary care physician acted on a hunch, just as the ER physician did. Why do you think the primary care physician's hunch was accurate whereas the ER physician's wasn't? Was it sheer luck – or something else?

8 What could have happened to the patient if her primary care physician had not discovered her allergy to the UTI medication? What could have been the effect on the ER doctor? The hospital?

9 What can physicians and other providers do to ensure that perceptual problems such as clinging to first impressions and jumping to conclusions do not lead to misdiagnoses?

10 What did this case teach you about the relationship between perceptions and medical errors?

## Training Tool #97

### CASE STUDY: CLOSE CALL

A distraught 52-year-old woman entered the emergency room, seeming to be hyperventilating and struggling to catch her breath. Through her tears, she explained that the problem started about an hour before. As indicated on her intake forms, the patient was taking several medications: an antidepressant, natural hormones, esomepazole for gastroesophageal reflux disease (GERD), a leukotriene receptor antagonist for her allergies, and a nitrofurantoin for a recent UTI.

When the emergency room physician asked about the reasons for the antidepressant, the patient began sobbing and explained that she recently lost two members of her family in a terrible car accident. When the doctor asked more about the onset of symptoms, he learned that it was during lunch with friends when she was describing the accident. When symptoms became severe, her friends rushed her to the hospital.

A brief exam did not reveal any obvious problems. The patient was asked to breathe into a paper bag, which seemed to help, and as an extra precaution, the doctor asked a pulmonary technician to give the patient an inhaler. The patient seemed to calm down as her symptoms subsided, and the physician suggested that the most likely cause of her problem was conversion disorder, which was not uncommon for people who suffered a tragedy.

After hearing that the conversion disorder is a psychiatric problem, the patient strongly protested the diagnosis. "I'm not crazy," she said. "My symptoms are real! I couldn't breathe!" The doctor explained that conversion disorder creates very real reactions, often affecting breathing. He suggested that she visit a psychiatrist or psychologist for follow-up care. Although the patient was relieved that her symptoms had abated, she made it clear that she didn't agree with the diagnosis and soon checked out of the ER.

The next day, the patient's symptoms not only returned, but worsened. Instead of going back to the ER, she went to her primary care physician's office as a walk-in (rather, a run-in) and explained the situation to him as she struggled for breath.

"Wait here a minute," the primary care physician said. "I need to check something on the computer." When the doctor returned, he told the patient that he had a confirmation that his hunch was most likely correct and read the following from a printout of the medication she had been taking for her UTI:

"Acute, subacute, or chronic pulmonary reactions have been observed in patients treated with nitrofurantoin. If these reactions occur, this medication should be discontinued and appropriate measures taken. Reports have cited pulmonary reactions as a contributing cause of death."

The primary care physician treated the patient's respiratory distress and advised her to discontinue the medication for her UTI. The patient's pulmonary symptoms never recurred.

# Communicating with your community

## Training Tool #98

**Defining and understanding the concept of care coordination**

# Care coordination

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 15 minutes

**THEMES:** Communicating with your community, coordination/consistency

**OBJECTIVE:**

- to define and understand the concept of care coordination within the community.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Begin by asking participants about the purposes and components of "care coordination" within the community. Write responses on the flip chart. Possible answers may include:

- to link patients with information and services throughout the community and help them navigate through the health care delivery system;
- to manage patients' and families' expectations;
- to promote follow-up and continuity of care;
- to provide support to patients and families;
- to maximize the use of community, family, and provider resources;
- to ensure better outcomes – not only health outcomes, but educational, vocational, psychosocial, and functional outcomes.

**DEBRIEFING:**

1. Why do you think coordination of care is even more important today than ever? (Possible responses may include: the increasing complexities and fragmentation in today's health care delivery systems; that people are living longer; that many of these people have multiple, chronic conditions requiring attention by numerous types of providers; and that many patients have social as well as physical needs.)
2. Who is responsible for care coordination? Is this mainly the responsibility of medical homes, managed care organizations, and social service agencies? Or is this a function of other health care providers as well? Please explain.
3. What are the special needs or circumstances of patients and families that would benefit most from care coordination? (Possible answers: those who are chronically ill; those who require care from multiple providers; those who are new to the community; those who need assistance in navigating the complex health care delivery system; and those with limited resources.)

**Identifying the keys and obstacles to building community partnerships**

## Training Tool #99

# Building community partnerships

**TYPE:** Introductory discussion

**ESTIMATED TRAINING TIME:** 30 minutes

**THEMES:** Communicating with your community, coordination/consistency

**OBJECTIVES:**

- to understand the need for planning in developing community health partnerships;
- to identify components of the planning process.

**MATERIALS NEEDED:** Flip chart

**PROCEDURE:**

Tell participants to select a purpose for developing community partnerships by your health care organization; for example, to build a practice; to increase a residency program's community involvement; or to collaborate on public health projects (e.g. health promotion) or social problems (e.g. teen pregnancy prevention) in order to create a healthier community. Point out that the example they select will be the basis of your all-group discussion.

**DEBRIEFING:**

1 What are the advantages of community partnerships?

(Responses may include the ability to: address complex social problems or specific areas of need; tap into one another's distinct areas of expertise; view health or social problems in a new light by combining perspectives; increase the level of support of the project through the involvement of each group's constituencies; integrate and coordinate services; avoid unnecessary duplication of effort within the community while maximizing resources; and achieve results that are greater than either organization could realize on its own.)

2 What considerations will you make when considering which organizations, agencies, or groups to invite as partners?

(Responses may include: determining which existing relationships require greater definition; identifying organizations in which no relationship currently exists but would be desirable; identifying mutual interests and needs; and identifying personnel, resources, or skills of each entity that would add to the joint effort, complement one another's programs and services, or fill gaps.)

3 What will you need to do to develop this community partnership? What will be on your organization's "to-do" list for determining how the new partnership will function?

(Responses may include: determining methods of data collection and assessing community needs; identifying the purposes of the collaboration; determining the roles and responsibilities of each party, including leadership, fund management, etc.; considering how parties will convene, communicate, make decisions, and address problems; identifying how to measure outcomes; determining how parties will achieve buy-in and participation from the community; determining procedures and timelines; monitoring implementation; etc.)

4 What obstacles could you possibly encounter?

(Possible answers include: time and effort for the joint effort as well as relationship maintenance; funding; difficulties in achieving consensus, particularly when issues are controversial or contentious; inter-group conflicts and power struggles; and competition for recognition or resources.)

5 How can these obstacles be overcome?

(Responses may include: anticipating problems, careful planning, utilizing communication and dispute resolution strategies to deal with any issues that arise, and follow-up monitoring. Some respondents also may suggest bringing in a neutral third-party facilitator.)

6 Based on our discussion thus far, how can you use the criteria to develop community partnerships for the purpose you have selected? What specific recommendations would you make for selecting and planning the partnerships?

7 What did this discussion teach you about the essentials and obstacles of building community partnerships?

A selection of cases to identify strategies for communicating with communities

## Training Tools #100–4

# Case studies on communicating with your community

**TYPE:** Case studies

**ESTIMATED TRAINING TIME:** 30 minutes

**THEME:** Communicating with your community

**OBJECTIVE:**

- to identify strategies for dealing with various types of glitches that may arise when developing or engaging in community partnerships.

**MATERIALS NEEDED:** A copy of the selected case study for all participants

**PROCEDURE:**

Ask participants to form small groups of four to six persons each. Then distribute one of the following case studies.

- **Willing to serve** – a community group complains that they are not represented on a county health department's Steering Committee to improve prenatal care.
- **Out of the loop** – A public representative complains about poor communication in a partnership organized by the county medical society.
- **Lack of trust** – A local hospital's immunization outreach project gets resistance from local providers.
- **Competing practice** – Physicians discuss ways to handle new competition from a nearby practice.
- **The shy doc** – A reserved physician wants the community to know about his experience in sports medicine.

Tell participants that they will have 15 minutes to address the questions following the case study, followed by an all-group discussion.

**DEBRIEFING:**

After hearing group reports on their discussions, summarize key points about the particular case and the lessons it teaches about communicating with one's community.

## Training Tool #100

### CASE STUDY: WILLING TO SERVE

A Steering Committee has been established by the county health department to improve prenatal care for low-income women in the community. Leaders of the health department have decided to limit membership on the Steering Committee to 15 persons from organizations that are broadly representative of groups that share their interest in improving prenatal care. All 15 positions have been filled.

Members of a group that advocates breastfeeding have complained to the local newspaper that their organization is not represented on the Steering Committee and suggest that "politics" must be involved. In fact, members of the Steering Committee have decided NOT to include this group because some of its leaders are considered as "disruptive." During a discussion on this matter, the Steering Committee noted that advocacy for breastfeeding is covered through representation by the county health department, two hospitals, and various medical and nursing groups.

### DISCUSSION QUESTIONS

1 Should the Steering Committee relent and allow the group representation on the Steering Committee? Please explain your response.
2 What might have been the impact from the group's public protest of the Steering Committee's decision about representation?
3 Now that the dispute has become public, how should the Steering Committee handle the matter with the newspaper and others throughout the community?
4 How would you advise the Steering Committee in regard to what and how it should communicate with members of the breastfeeding group?
5 Should efforts be made to resolve the problems with this community group? If so, what should be done?
6 If problems with the breastfeeding group can be resolved, should the composition of the Steering Committee be changed? Why or why not? Should the advantages in keeping the planning group to a reasonable size be a factor in this decision?
7 Is there another way to address the breastfeeding group's desire for inclusion without allowing them a seat on the Steering Committee? If so, what would you suggest?

## Training Tool #101

### CASE STUDY: OUT OF THE LOOP

Several months ago, the county medical society initiated a community-wide health promotion effort to combat childhood obesity, which has become epidemic in the area. Participants include physicians, nurses, physician assistants, nutritionists, pharmacists, social workers, and members of the general public. Because there are many different aspects to this program (e.g. giving talks at schools, developing brochures on healthy eating, supporting a local ordinance to limit fast-food establishments in proximity to schools, etc.), numerous committees and subcommittees have been established. Some of these groups have been functioning autonomously and, although they are producing excellent results, their independence makes some of their activities difficult to track.

While communication problems have been reported by several types of professionals involved in the committees and subcommittees, public representatives have been the most vocal. "We often don't know about upcoming meetings or late-breaking developments until we read about them in the newspaper," a public representative says. "Health care professionals often share information when they see each other at the hospital or professional meetings, but we're the last to know."

### DISCUSSION QUESTIONS

1 What are the possible causes of the communication breakdowns in this project?
2 Is cross-communication among the committees and subcommittees necessary, since all of these groups are doing their jobs? Why or why not?
3 What suggestions can be offered to improve communication? What communication channels and methods could be used?
4 Because public representatives are most vocal about the communication glitches, should special efforts be targeted to improve communication with them? Why or why not? If yes, what special efforts would you recommend?

## Training Tool #102

### CASE STUDY: LACK OF TRUST

Administrators of a community hospital have asked physicians and other providers from several private practices to participate in an immunization outreach project. Some are leery of accepting, even though they believe the project has merit.

There are many reasons for this resistance. Some see this as a ploy by the hospital to build allegiances that will increase patient admissions. (For the past two years, many physicians and other providers have been bypassing the local hospital in favor of a larger facility in a neighboring community.) Some are concerned with nursing shortages at the local hospital. Others complain that local administrators don't take their input seriously.

### DISCUSSION QUESTIONS

1 What can be done to alleviate the strain between the local hospital's administrators and the physicians and other providers throughout the community?
2 What are the possible impacts on the local hospital if these relationships are not improved? What could be the effect on people who reside in the community?
3 Would it matter if the local hospital administrators did have an ulterior motive for this outreach project; for example, to improve relationships with private practices? Why or why not?
4 What can be done to reestablish trust among these parties? What changes might the hospital need to make? What communication and relationship-building strategies would you suggest?
5 Even if the current problems are resolved, what steps can the local hospital take to ensure that there isn't a breakdown of trust with physicians and other providers in the future?

## Training Tool #103

### CASE STUDY: COMPETING PRACTICE

For the past five years, you and a partner have had a successful family medicine practice in a rural community with a population of 26 000. Your practice also draws patients from small neighboring towns totaling 10 000 persons more. Another physician in town, Dr. Singleton, is in solo practice. You, your partner, and Dr. Singleton have good rapport and share call.

A few months ago, a new practice opened up in town that has two recently graduated family physicians and a nurse practitioner. Dr. Singleton doesn't seem to be too concerned about the new practice, but you and your partner are concerned about the increasing competition.

Among other strategies to maintain your practice's viability, you and your partner agree that it would be a good idea to increase your presence in the community. Sure, you've been out-and-about in the community with your respective families, but have not planned or coordinated your community involvement efforts in any formal way. With the new competition in town, it's time to begin.

### DISCUSSION QUESTIONS

1 As you expand your networking within the community, what types of activities can you and your partner pursue?
2 What types of organizations and individuals should be the targets of your efforts?
3 How will you be able to assess the success of these efforts?
4 What can you do to reinforce loyalty of your current patients?
5 In conversations with community members, what are the perils of comparing your practice with the competing group?
6 Will you make efforts to welcome the new providers to the community? Why or why not? Does the fact that you consider them as "competition" have a bearing on your decision?

## Training Tool #104

### CASE STUDY: THE SHY DOC

You are a recent residency graduate and have just moved to your practice from another State. As such, you don't know a lot of people in your community except for those in your own practice. You have a special interest in sports medicine, and have been trying to build more of a reputation for your skills in that area. Your partners have asked that you develop a list of suggestions on what you could do to promote that expertise and have said that they will help you in any way they can.

As you determine how to promote your interest and expertise in sports medicine, you will look for ways to promote yourself that are most comfortable for you, considering that you are somewhat shy. Although you feel quite comfortable in interpersonal conversations, you often feel uneasy in group gatherings, especially with people you don't yet know. For you, public speaking is out of the question.

### DISCUSSION QUESTIONS

1 What steps can you take to become more integrated in your new community?
2 What can you do to promote your special expertise in sports medicine?
3 What else could you do if shyness were not an issue?
4 What will you suggest that your partners can do to help?

**Various facilities in a rural community consider ways to increase collaboration**

## Training Tool #105

# Trouble in paradise

**TYPE:** Role play – five players

**ESTIMATED TRAINING TIME:** 90 minutes

**THEME:** Communicating with your community, coordination/consistency

**OBJECTIVES:**

- to identify ways to convert problem relationships into collaborative ones;
- to show the importance of meeting each organization's needs while acting in the interest of the greater good for the community.

**MATERIALS NEEDED:** A copy of the "General Instructions" for all participants, and a copy of the five roles for each small group

**PROCEDURE:**

Explain that the purpose of this role-playing exercise is to establish a partnership in the town of Paradise in order "to improve the community's ability to provide accessible and economical health care services." The player representing the State Office of Rural Health (Rue L. Helzkerr) will serve as meeting facilitator. Other players include: Hoss Pittle, representing Paradise Community Hospital; I. Mary Care, MD, of the Family Medicine Clinic; Al Derly, from the area's long-term care (LTC) facility, and John Q. Public, Director of the local Department of Public Health. Participants should begin the exercise as soon as they have finished reading their instructions.

Divide participants into groups of five. Distribute the "General Instructions" to everyone, and the "Confidential Instructions" for each person's role. Note that the groups will have 60 minutes to complete the role play.

**DEBRIEFING:**

When the time for this exercise has expired, ask each group to discuss the following questions. Each group should designate a "reporter" to summarize the discussion to the group as a whole. Remind participants that there are lessons to be learned from this exercise, whether they developed partnerships or not.

1. Were the players successful in achieving a partnership? What factors contributed to the outcome?
2. Which party or parties were responsible for a successful outcome?
3. Did the emotional aspect of these relationships impede the group's ability to deal with substantive matters? If so, how did the group address this?

4 What communication strategies were used to uncover each player's hidden agenda and concerns?
5 Were individual positions converted into group interests? If so, how? What were the effects?
6 Did parties listen effectively to one another? If not, what caused some players to "tune out"?
7 How well did the State Office of Rural Health representative mediate? What other strategies might have been used?
8 What opportunities for solutions became apparent as the various players revealed their concerns to their counterparts?
9 Did the group address ways to avoid similar conflicts and problems in the future?
10 Based on the lessons from this exercise, what would your group suggest to health care professionals who might face a similar situation in real life?

**NOTE TO INSTRUCTOR:**

As you review the outcomes for this exercise during the debriefing session, you may wish to point out the following recommendations from Gary Zaborac, Director of Public Health at the Clay County Public Health Center in Liberty, Missouri:

> If I had to pick a realistic outcome for the discussions, it would be the formation of a community health team, which would include other community leaders, organizations, and private citizens that come together to address the concerns identified. Certainly a reorganization of the existing health care delivery model for Paradise, which may include the formation of a Federally Qualified Health Center (FQHC), is in order.

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE
GENERAL INSTRUCTIONS

**Players:**
**Rue L. Helzkerr – Representative of the State Office of Rural Health (SORH)**
**Hoss Pittle – Representative of Paradise Community Hospital**
**I. Mary Care, MD – Representative of the Family Medicine Clinic**
**Al Derly – Representative of the Long-term Care Facility**
**John Q. Public – Director of the local Department of Public Health**

Paradise is a small town with a population base of around 10 000 persons. Senior citizens comprise 30% of the drawing population from surrounding areas. The number of elderly persons is expected to increase over the next 10 years. Lately, the local newspaper (*The Sun*) printed a story about the area's worsening economic condition. In addition to describing the closing of several local businesses, the article cited the continued attrition of young families who are leaving Paradise for larger communities (especially Gimmemore, which is about 60 miles away).

Five entities are currently providing health care services in Paradise: a 35-bed rural hospital off of Main Street; two family medicine clinics, each with two family physicians and two nurse practitioners, both near the hospital; a 90-bed long-term care facility across town, and the local Department of Public Health. Except for the public health department, which has made it a point to communicate frequently with others in the community, the others interact as little as possible. In fact, there has not been a good working relationship among the other facilities for many years now.

The SORH has been extremely concerned about this lack of collaboration and has decided to bring representatives from these facilities together for a meeting with the explicit purpose of "improving the community's ability to provide accessible and economical health care services for the people of Paradise and surrounding areas." That meeting is scheduled for today.

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE
CONFIDENTIAL INSTRUCTIONS

**Rue L. Helzkerr**

**Representative of the State Office of Rural Health (SORH)**

As the SORH sees it, the providers in Paradise could provide better and more economical services if only they would agree to work together. At this meeting, you are the "mediator" who will try to get these groups to talk to one another. Although it seems like pulling teeth to even get these representatives together, you are very pleased that you were successful in getting them to attend. You've had a lot of support from the local public health department, as they are the only group that has maintained regular contact with the others.

Since you don't know any of the representatives well, you are not sure WHY communication is such a problem, especially in such a small town! What are the issues that keep them from working together?

These questions keep occurring to you:

1 How can we get these folks to work together more effectively?
2 What does SORH need to do to be more helpful to them?
3 How can these players develop a shared vision and see the "big picture"?
4 How can we convince them to think in terms of a "win-win" outcome for the community?

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE
CONFIDENTIAL INSTRUCTIONS

**Al Derly**
**Representative of the Long-Term Care Facility**

You resent even coming today, but you did at the urging of the State Office of Rural Health. Besides, it would look bad if representatives of the hospital and family medicine clinic showed up and you didn't.

Your long-term care facility is doing so well that you wonder why you'd even need to work more closely with the others. You're proud that your facility consistently has 95–100% occupancy. You've even had to turn prospective residents away! While this is probably due to the growing elderly population in the area, your very successful (and aggressive) marketing campaign and the excellent reputation of your facility certainly haven't hurt!

You consider the doctors at the family medicine clinic to be fairly elitist. Sure, they provide coverage at your facility and the residents are satisfied with their care, but they don't "go the extra mile." They only do the minimum work necessary and seem fairly detached from your facility's goals.

With regard to the hospital, you see the administrators as money-grubbing vultures who directly compete for your long-term care patients. You resent the fact that they have converted so many swing beds to long-term care. After all, they couldn't possibly provide the high-quality care that you do. You have told many of your friends and colleagues in the community your feelings about this and consider yourself to be an open, honest, and outspoken person who looks out for the well-being of those you serve.

Despite the fact that your facility is doing quite well, you are always mindful of the need to watch your bottom line. You are concerned about the impact that increasing the number of Medicaid and Medicare beds will have on your organization.

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE

CONFIDENTIAL INSTRUCTIONS

**I. Mary Care, MD**

**Representative of the Family Medicine Clinic**

One thing that rankles you is when you're accused of "not playing ball" with the other health care providers in the community. You and your colleagues at the family medicine clinic provide coverage at the long-term care facility. You and they have privileges at Paradise Community Hospital and refer a significant number of patients there. Sure, you have been referring an increasing number of patients to Gimmemore Hospital, which is 60 miles away, but that's because you believe that the hospital in Paradise isn't nearly as good at providing care for your cardiac patients or for high-risk OB patients who need more specialized equipment and services. For the most part, you've been working with the local providers as much as you possibly can.

From your perspective, you need to devote your concentration to your practice – not to other providers. You've had an unusually high attrition of staff from your office and it's putting a lot of pressure on those who remain. Besides, it may be a while before you can replace those who have left. You've advertised in other towns to get assistants and a receptionist to apply, but none of the applicants to date have qualified.

Another reason you need to focus internally is to build the practice's income. While your colleagues are busy now, you're concerned about the attrition of many young families from Paradise. You're tired of treading water! With everything invested in your practice, there's nothing more important to you (except your family) than having the practice succeed.

You're leery of the people you're meeting with today. Why is the hospital trying to take patients away from your practice through their ambulatory programs? You try to stay away from the folks at the long-term care facility. All they seem to do is fight with the hospital for elderly residents. They are always trying to put the doctors in the middle of their disputes.

Although you are dedicated to community work, your practice is struggling so much right now that the continued increases in Medicaid patients in your practice are compromising your ability to remain financially viable.

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE
CONFIDENTIAL INSTRUCTIONS

**Hoss Pittle**
**Representative of the Paradise Community Hospital**

You're not looking forward to today's meeting. It took some major convincing from the SORH people to even get you to agree to attend. Based on your past interactions with the other providers and the long-term care facility, you expect that this will be a colossal waste of time.

As you see it, the family medicine clinic and the long-term care facility just don't understand the importance of the hospital to the community. It's the area's largest single employer. Without the hospital, several of the remaining businesses wouldn't stay around. The hospital is finally in the black (just barely), and you'd like it to stay that way. As recently as two years ago, the hospital was in such a dire financial situation, your Board of Trustees had even discussed closing it down.

The family medicine clinic and long-term care facility seem to be working against the hospital rather than trying to help it survive. Although the family medicine clinic refers some patients to your hospital, you have been extremely concerned that the doctors there (who have privileges at your hospital) are referring an increasing number of patients to Gimmemore Hospital, 60 miles away. Some OB patients have been referred to Gimmemore who could have easily been managed in Paradise. You are especially upset that some are referring even the simplest cardiac cases to Gimmemore!

The long-term care facility isn't helping either. Due to changes in reimbursement, your hospital isn't doing much long-term care business, which you need to fill your swing beds. While you really need those elderly patients, the long-term care facility has been very aggressive in its marketing. You've even heard that they've been badmouthing the care provided at your hospital. Since the long-term care facility has such high occupancy, you find these attacks especially disheartening.

You've been trying to take the bull by the horns and have started several ambulatory services to attract more patients, but the results have been minimal at best. That could be due, in part, to the fact that the local public health department already provides outreach services in their clinic, in schools, and throughout the area. In regard to the SORH, you don't see how they can help you. The situation in the community has been going on for some time now, and you don't see how the SORH can make the family medicine clinic and the long-term care facility come to their senses.

## Training Tool #105

### ROLE PLAY: TROUBLE IN PARADISE
CONFIDENTIAL INSTRUCTIONS

**John Q. Public**
**Director of the Local Department of Public Health**

You have been the Director of the local Department of Public Health for the past three years. When you arrived in Paradise, your community Board of Directors asked if you would concentrate on developing relationships with various partners throughout the area. You take pride in the partnerships you have created and work to ensure that these are not "name-only" arrangements. You have joined several service clubs, attend community events, actively involve your partners in activities of mutual interest, and communicate with each partner as regularly as time allows.

You are very happy that the SORH decided to convene this meeting to bring all of the local players together; in fact, you had offered to host such a meeting in the past but with no success. You wish that financial issues were not as much at the core of people's decision making. It concerns you greatly that your public health clinic is becoming overwhelmed by patients. You have urged the family medicine clinic to help out by seeing more Medicaid patients, but they tell you that as much as they would like to help, it isn't financially feasible to do so at the current time. Ideally, you would like to see *all* of the facilities in Paradise pitch in.

The long-term care facility hasn't been very helpful either. Your staff has often referred elderly patients and those with special needs to the long-term care facility, but they complain that patients on Medicaid should be referred to the local hospital instead. The hospital complains that they are getting more than their share of government-assisted patients, which not only creates more paperwork, but also affects them financially.

You consider yourself quite skilled in developing creative solutions to problems such as this one, and you plan to offer some suggestions at this meeting to (a) improve communication among the health facilities in Paradise; (b) ensure that public-assisted patients are shared by each entity; and (c) identify ways to work together more effectively on public health issues affecting the entire community.

## Appendix A

# Tips for trainers

- **Select a private room for training activities.** Test any audio-visual equipment before the program. Keep an extra bulb on hand for overhead projectors. Ask participants to use "vibrating" beepers in order to avoid distractions.
- **Do your homework.** If you are training 10 health care professionals in a one hour session, realize that you're utilizing 10 total hours of people's time – and that's an investment. Make their time count by developing a well-structured agenda and doing the necessary research in advance.
- **Vary your activities.** The experiential approach ("learning-by-doing") is an excellent way to provide training in communication-related strategies. Incorporate several training methods into your program by using a combination of activities, such as didactic presentations, self-tests, films, role-playing exercises, case studies, group discussions, problem-solving sessions, and audio-visual presentations.
- **Encourage participants to "stretch."** When role-playing, some participants may balk at playing the roles of persons in other specialties, professions, or disciplines. If this occurs, you can either modify the exercises to suit the participants, or ask participants to put themselves in their respective character's shoes. Explain that this will help them see the conflict from another party's perspective.
- **Be a good teacher.** When presenting a didactic lecture, make your points come alive by using metaphors and relevant examples. Explain new terminology. Use visual aids as appropriate. Lace your talk with humor to keep your audience awake and interested.
- **Be a good facilitator.** One of the best ways to ensure a good learning experience is to help participants process the lessons from each exercise through well-facilitated group discussions. Vary the pace of the program, ask "answerable" questions, summarize points, and keep things moving. Be sure to allow for a sufficient amount of discussion time before rushing to the next activity.
- **Evaluate the training session.** At the conclusion of the program, ask participants to complete an evaluation form so that you can improve future training programs. Keep the form brief with questions such as: Was this program helpful to you? Why or why not? What did you find most beneficial . . . and the least? What suggestions do you have for future training topics? Any other comments or suggestions?

## Appendix B

# The art of giving critiques

When doing role-play exercises, participants will learn through their participation as well as through critiques by the instructor and other trainees. To ensure that participants will be receptive to these critiques, it's important to avoid embarrassing, hurting, or offending those who need to improve their skills in certain areas. Anyone who is asked to critique others should consider these suggestions.

➥ **Remember: critiques are to reinforce the positives too!**
It's not uncommon for people to think of critiques as telling others what they didn't do as well as they should or what they need to improve upon. That's part of it, but not all. Critiques are also for the purpose of explaining what others do well, as that will encourage them to continue using those practices in the future. So don't forget to reinforce the strengths that you see in others!

➥ **Make observations, not conclusions.**
To show the difference between these two concepts, an observation would be "You're late" while a conclusion would be "You're irresponsible!" Applying this to critiques, be sure that you explain what you saw the other party do or what you heard them say that needs to be tweaked or improved. Avoid making blanket statements that appear to be a conclusion about the other person.

➥ **Criticize the act, not the person.**
Parents today learn that they shouldn't say, "Billy, you're a bad boy" because Billy is not a bad person – he just did something wrong. Modern day parents are advised to say instead, "Billy, you're a great kid and I love you – but your behavior right now is unacceptable!" We need to do the same thing when giving effective critiques: separate the people from the problem. If a trainee needs to improve a skill, mention what needs to be improved, but don't diminish the person in the process.

➥ **Keep comments professional, not emotional.**
Critique sessions aren't the time to get back at a colleague for things they've done or said in the past. The focus needs to be on the exercise under discussion. Keep the discussion professional and make it a point to avoid confusing the discussion with old emotional baggage.

➥ **Concentrate on improving skills, not placing blame.**
The learning curve will vary for all of those who engage in training exercises as they try to learn new skills and discard old habits that don't work in their favor. Don't blame them for their missteps; remember that this is a learning atmosphere and that people learn as much from their mistakes as they do their successes!

## Appendix C

# Quotations on training topics

Note: These topics are listed in the same order as the exercises appear throughout the book.

### LISTENING

"It seemed rather incongruous that in a society of super-sophisticated communication, we often suffer from a shortage of listeners." – Erma Bombeck

"The most important thing in communication is to hear what isn't being said." – Peter Drucker

"Nature has given us one tongue but two ears, that we may hear from others twice as much as we speak." – Epictetus

"Sometimes, the most revealing part of a message isn't found in the words themselves but in the subtle messages wrapped around those words. Failure to pick up on these 'secret messages' may leave you blind to what is really being communicated." – Dianne Booher

"My wife says I never listen to her. At least I think that's what she said." – Anonymous

"In some South Pacific cultures, a speaker holds a conch shell as a symbol of temporary position of authority. Leaders must understand who holds the conch – that is, who should be listened to and when." – Max De Pree

"It's a rare person who wants to hear what he doesn't want to hear." – Dick Cavett

"You cannot truly listen to anyone and do anything else at the same time." – M. Scott Peck, MD.

"Big egos have little ears." – Robert Schuller

"The greatest compliment that was ever paid me was when one asked me what I thought, and attended to my answer." – Henry David Thoreau

"Seek first to understand, then to be understood." – Stephen R. Covey

"To say that a person feels listened to means a lot more than just their ideas get heard. It's a sign of respect. It makes people feel valued." – Deborah Tannen

"An essential part of true listening is the discipline of bracketing, the temporary giving up or setting aside of one's own prejudices, frames of reference and desires so as to experience as far as possible the speaker's world from the inside, step inside his or her shoes. This unification of speaker and listener is actually an extension and enlargement of ourselves, and new knowledge is always gained from this. Moreover, since true listening involves acceptance, the speaker will feel less and less vulnerable and more and more inclined to open up the inner recesses of his or her mind to the listener." – M. Scott Peck, MD

### IMPROVING PATIENT RELATIONSHIPS

"To build loyal patient relationships, you must meet or manage the specific expectations of each patient." – Susan Keene Baker, *Managing Patient Expectations*

"The doctor may learn more about the illness from the way the patient tells the story than from the story itself." – James B. Herrick

"Some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician." – Hippocrates

### CUSTOMER SERVICE STRATEGIES

"After years of focusing on costs, trailblazing health care organizations are recognizing that impressive customer service will set them apart. They recognize the need not only to satisfy, but to *impress* their customers, to dazzle them, in order to win their loyalty." – Wendy Leebov, Gail Scott, and Lolma Olson, *Achieving Impressive Customer Service: 7 strategies for the health care manager*

"There are no traffic jams along the extra mile." – Roger Staubach

"Knowing that expectations are higher in health care than in other businesses, it only makes sense to strive for excellence rather than simply hoping not to offend the customer." – Kristin Baird, *Customer Service in Health Care*

### DEALING WITH CUSTOMER COMPLAINTS

"To hear complaints with patience, even when complaints are vain, is one of the duties of friendship." – Samuel Johnson

"To consider complaints as gifts, we first have to accept the notion that customers always have a right to complain – even when we think their complaints are stupid, unreasonable, or cause inconveniences." – Janelle Barlow and Claus Moller, *A Complaint is a Gift: using customer feedback as a strategic tool*

"Customer complaints are opportunities for building customer loyalty. Sure, complainers can be annoying, but they can also be your best friend. They can point out ways to improve and strengthen your business in ways no one else will." – Paul R. Timm, *Customer Service: career success through customer satisfaction*

### MANAGING PATIENT EXPECTATIONS

"The purpose of managing expectations is to have as little discrepancy as possible between patients' expectations and their actual experience. Maintaining a balance of consistency and flexibility allows you to accomplish this." – Susan Keene Baker, *Managing Patient Expectations*

### CONFIDENTIALITY AND PRIVACY ISSUES

"Unless protecting patient privacy and confidentiality is a fundamental part of your health care organization's culture, there will always be staff who think of those policies and procedures as just another dusty manual on the shelf or as rules that only apply to other people." – Jill Callahan Dennis, *Privacy & Confidentiality of Health Information*

### INTERCULTURAL COMMUNICATION

"What would it be like to have not only color vision but culture vision, the ability to see the multiple worlds of others." – Mary Catherine Bateson

"Because the individuals who participate in the modern health care delivery system represent such a broad range of different cultural beliefs, attitudes, and values, modern health care has inevitably become an increasingly multicultural enterprise. In such an environment, effective health care delivery demands sensitivity to cultural differences." – Gary G. Kreps and Elizabeth N. Kunimoto, *Effective Communication in Multicultural Health Care Settings*

"Effective cross-cultural communication requires awareness that communication is possible and that mistakes will occur, sensitivity to the communication process, knowledge of expectable patterns of communication styles that are appropriate to the client, and a set of practiced skills." – Kathryn Hopkins Kavanagh and Patricia H. Kennedy, *Promoting Cultural Diversity: strategies for health care professionals*

"If we are to achieve a richer culture, rich in contrasting values, we must recognize the whole gamut of human potentialities, and so weave a less arbitrary social fabric, one in which each human gift will find a fitting place." – Margaret Mead

### COMMUNICATING FOR COORDINATION AND CONSISTENCY

"Just because an organization has numerous services within its corporate umbrella or its affiliation network does not mean that those services are coordinated in a way that is either efficient for providers or easy for consumers. Thus, coordination and linkage among services become the challenge." – Connie J. Evashwick, *Seamless Connections: refocusing your organization to create a successful continuum of care*

"In any team sport, the best teams have consistency and chemistry." – Roger Staubach

"Of all the things I've done, the most vital is coordinating those who work with me and aiming their efforts at certain goals." – Walt Disney

### COMMUNICATING TO PREVENT AND REDUCE MEDICAL ERRORS

"Surgeons must be very careful, when they take the knife!
Underneath their fine incisions, stirs the culprit – *life!*" – Emily Dickinson

"It is unwise to be too sure of one's own wisdom. It is healthy to be reminded that the strongest might weaken and the wisest might err." – Mahatma Gandhi

"Make it compulsory for a doctor using a brass plate to have inscribed on it, in addition to the letters indicating his qualifications, the words, 'Remember that I too am mortal.'" – George Bernard Shaw

"The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. This does not mean that individuals can be careless. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error." – Institute of Medicine, *To Err is Human: building a safer health system*

### COMMUNICATING WITH YOUR COMMUNITY

"The objective is to create a true relationship between the community and your facility. To do this requires the *active and routine involvement* of all Associates in some aspect of the community." – Stephanie G. Sherman with V. Clayton Sherman, *Total Customer Satisfaction: a comprehensive approach for health care providers*

"The pathos of man is that he hungers for personal fulfillment and for a sense of community with others." – J. Saunders Redding

"Without a sense of caring, there can be no sense of community." – Anthony J. D'Angelo

"What we have to do . . . is to find a way to celebrate our diversity and debate our differences without fracturing our communities." – Hillary Rodham Clinton

## Matrix 1: Exercises by training subject

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| **Effective listening** | | | | | | |
| 1 Practice in effective listening | 3 | X | | | | |
| 2 The look of listening | 6 | X | | | | |
| 3 Intro to listening | 7 | X | | | | |
| 4 Person-to-person | 8 | X | | | | |
| 5 20 questions | 12 | X | X | X | | |
| 6 Organizational listening | 17 | X | | | | |
| 7 Listening between the lines | 21 | X | | | | |
| 8 Are YOU a good listener? | 23 | X | | | | |
| 9 Faulty listening habits | 32 | X | | | | |
| 10 Excuse my back | 36 | X | X | X | | |
| 11 Getting the patient's story | 39 | X | X | X | | X |
| 12 True confessions | 45 | X | X | X | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 13 Behind closed doors | 50 | X | X | | | |
| **Improving patient relationships** | | | | | | |
| 14 Effective patient relationships | 57 | | X | X | | |
| 15 Patient relationships: what not to do | 58 | | X | X | | |
| 16 Cool reception | 62 | | X | X | | |
| 17 Between visits | 68 | | X | X | | |
| 18 Anxious moments | 69 | | X | X | | |
| 19 Lucky you | 74 | | X | X | | |
| 20 Love me, love me not | 81 | | X | X | | X |
| 21 Drama queen | 83 | | X | X | | X |
| 22 The maddening patient | 84 | | X | X | | X |
| 23 The worried well | 85 | | X | X | | X |
| 24 Social hour | 86 | | X | X | | X |
| 25 A personal matter | 87 | | X | X | | |
| 26 No stupid questions | 90 | | X | X | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | X | | | | |
| | | | | | |
| | X | | | | |
| | | X | | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 27<br>Vague comfort | 93 | | X | X | | |
| 28<br>Believe me | 96 | | X | X | | |
| **Customer service strategies** | | | | | | |
| 29<br>Shaping perceptions | 103 | | X | X | | |
| 30<br>Customer service needs | 104 | | X | X | | |
| 31<br>In the patient's shoes | 105 | | X | X | | X |
| 32<br>Going the extra mile | 107 | | X | X | | X |
| 33<br>What would Disney do? | 113 | | X | X | | X |
| 34<br>And the winner is . . . | 116 | | X | X | | |
| 35<br>Small world | 119 | | X | X | | |
| 36<br>Point of no return | 121 | | X | X | | |
| 37<br>The great escape | 123 | | X | X | | |
| 38<br>The fall | 125 | | X | X | X | X |
| 39<br>A pain in the neck | 128 | | X | X | | X |
| 40<br>From no to yes | 132 | | X | X | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | X | | | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| **Customer complaints** | | | | | | |
| 41 Emotional responses to complaints | 137 | | X | X | X | |
| 42 Addressing customer complaints | 138 | | X | X | X | |
| 43 An exchange of letters | 140 | | X | X | X | |
| 44 Hot shot | 145 | | X | X | X | X |
| 45 Excuse me | 146 | | X | X | X | X |
| 46 Delay in billing | 147 | | X | X | X | X |
| 47 Today's the day | 148 | | X | X | X | X |
| 48 To refer or not to refer | 149 | | X | X | X | X |
| 49 The extended visit | 156 | | X | X | X | X |
| 50 The waiting game | 158 | | X | X | X | X |
| 51 Service with a smile | 160 | | X | X | X | |
| **Managing patient expectations** | | | | | | |
| 52 About patient expectations | 167 | | X | X | | X |
| 53 Great expectations | 168 | | X | X | | X |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 54 See me now | 171 | | X | X | X | X |
| 55 Living in fear | 172 | | X | X | | X |
| 56 Quick fix | 173 | | X | X | | X |
| 57 Request for referral | 174 | | X | X | | X |
| 58 Ready, set, go | 175 | | X | X | | X |
| 59 A long explanation | 178 | | X | X | | X |
| 60 The magic pill | 182 | | X | X | | X |
| 61 Just my luck | 185 | | X | X | | X |
| **Confidentiality and privacy issues** | | | | | | |
| 62 Confidentiality in health care settings | 191 | | | | | |
| 63 A place for everything | 192 | | | | | |
| 64 On the line | 195 | | | | | |
| 65 The promise | 199 | | | | | |
| 66 Ms. Mouth | 200 | | | | | |
| 67 Pressure at home | 201 | | | | | |
| 68 The inquiring spouse | 202 | | | | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | X | | | | |
| | X | | | | |
| | X | | | | |
| | X | | | | |
| | X | | | | |
| | X | | | | |
| | X | | | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 69 In plain sight | 203 | | | | | |
| 70 Celebrity secrets | 204 | | | | | |
| 71 Sex in the city | 207 | | | | | |
| **Inter-cultural communication** | | | | | | |
| 72 Dispelling the myths | 217 | | X | X | | |
| 73 Communication essentials for multicultural care | 220 | | X | X | | |
| 74 The culturally friendly practice | 222 | | X | X | | |
| 75 Coffee time | 224 | | | | | |
| 76 Professionally speaking | 225 | | | | | |
| 77 Take my advice | 226 | | | | | |
| 78 Traditional treatment | 227 | | X | X | | |
| 79 Hard labor | 231 | | X | X | | |
| 80 Invisible differences | 234 | | X | X | | |
| **Coordination and consistency** | | | | | | |
| 81 An interesting paradox | 241 | | | | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | X | | | | |
| | X | | | | |
| | X | | | | |
| | | | | | |
| | | X | | | |
| | | X | | | |
| | | X | | | |
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| | | X | | | |
| | | X | | | |
| | | X | | | |
| | | X | | | |
| | | | | | |
| | | | X | | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 82 Enhancing coordination | 243 | | | | | |
| 83 Refining referrals | 245 | | | | | |
| 84 The shift change | 247 | | | | | |
| 85 Past and present | 251 | | | | | |
| 86 Bewitching encounter | 253 | | | | | |
| 87 Dropping the ball | 256 | | | | | |
| 88 Meeting madness | 258 | | | | | |
| **Prevent/reduce medical errors** | | | | | | |
| 89 Root causes of medical errors | 263 | | | | | |
| 90 Coping skills | 264 | | | | | |
| 91 Friend of the family | 265 | | | | | |
| 92 Mum's the word | 270 | | | | | |
| 93 Who's on first? | 271 | | | | | |
| 94 Is no news good news? | 272 | | | | | |
| 95 Two birds, one stone | 273 | | | | | |
| 96 Hammer and nails | 274 | | | | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | X | | |
| | X | | X | | |
| | | | X | X | |
| | | | X | X | |
| | | X | X | X | |
| | | | X | X | |
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| | | | | X | |
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| | | | | X | |
| | | | | X | |
| | | | X | X | |

| Title | Page | Effective listening | Patient relationships | Customer service | Customer complaints | Patient expectations |
|---|---|---|---|---|---|---|
| 97<br>Close call | 276 | | | | | |
| **Communicating with your community** | | | | | | |
| 98<br>Care coordination | 283 | | | | | |
| 99<br>Building community partnerships | 284 | | | | | |
| 100<br>Willing to serve | 287 | | | | | |
| 101<br>Out of the loop | 288 | | | | | |
| 102<br>Lack of trust | 289 | | | | | |
| 103<br>Competing practice | 290 | | | | | |
| 104<br>The shy doc | 291 | | | | | |
| 105<br>Trouble in paradise | 292 | | | | | |

| | Confidentiality/ privacy | Intercultural communication | Coordination/ consistency | Prevent/reduce medical errors | Communicating with your community |
|---|---|---|---|---|---|
| | | | | X | |
| | | | | | |
| | | | X | | X |
| | | | X | | X |
| | | | | | X |
| | | | | | X |
| | | | | | X |
| | | | | | X |
| | | | | | X |
| | | | X | | X |

## Matrix 2: Exercises by profession

Note: An "X" in parentheses (X) indicates other types of professions that may be substituted for one of the characters in the exercise or that may find the exercise relevant to what they do.

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| **Effective listening** | | | | | | | | |
| 1 Practice in effective listening | 3 | X | | | | | | |
| 2 The look of listening | 6 | X | | | | | | |
| 3 Intro to listening | 7 | X | | | | | | |
| 4 Person-to-person | 8 | X | | | | | | |
| 5 20 questions | 12 | | X | X | X | | X | |
| 6 Organizational listening | 17 | X | | | | | | |
| 7 Listening between the lines | 21 | X | | | | | | |
| 8 Are YOU a good listener? | 23 | X | | | | | | |
| 9 Faulty listening habits | 32 | X | | | | | | |
| 10 Excuse my back | 36 | | X | (X) | (X) | | (X) | |
| 11 Getting the patient's story | 39 | | X | (X) | (X) | | (X) | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| 12<br>True confessions | 45 | | X | (X) | (X) | | (X) | |
| 13<br>Behind closed doors | 50 | | X | (X) | (X) | | (X) | |
| **Improving patient relationships** | | | | | | | | |
| 14<br>Effective patient relationships | 57 | X | | | | | | |
| 15<br>Patient relationships: what not to do | 58 | | X | X | X | | X | |
| 16<br>Cool reception | 62 | | | X | | | | X |
| 17<br>Between visits | 68 | X | | | | | | |
| 18<br>Anxious moments | 69 | X | | | | | | |
| 19<br>Lucky you | 74 | | X | X | (X) | | (X) | |
| 20<br>Love me, love me not | 81 | | X | (X) | (X) | | (X) | |
| 21<br>Drama queen | 83 | | X | (X) | (X) | | (X) | |
| 22<br>The maddening patient | 84 | | X | (X) | (X) | | (X) | |
| 23<br>The worried well | 85 | | X | (X) | (X) | | (X) | |
| 24<br>Social hour | 86 | | X | (X) | (X) | | (X) | |
| 25<br>A personal matter | 87 | | X | (X) | (X) | | (X) | |
| 26<br>No stupid questions | 90 | X | | | | | | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| 27 Vague comfort | 93 | | | | | | | X |
| 28 Believe me | 96 | | X | X | X | | X | |
| **Customer service strategies** | | | | | | | | |
| 29 Shaping perceptions | 103 | X | | | | | | |
| 30 Customer service needs | 104 | X | | | | | | |
| 31 In the patient's shoes | 105 | X | | | | | | |
| 32 Going the extra mile | 107 | X | | | | | | |
| 33 What would Disney do? | 113 | X | | | | | | |
| 34 And the winner is . . . | 116 | X | | | | | | |
| 35 Small world | 119 | | (X) | (X) | (X) | | | X |
| 36 Point of no return | 121 | | (X) | (X) | X | | (X) | |
| 37 The great escape | 123 | | (X) | X | (X) | | (X) | |
| 38 The fall | 125 | | X | X | (X) | X | | |
| 39 A pain in the neck | 128 | | X | (X) | (X) | | (X) | |
| 40 From no to yes | 132 | X | | | | | | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| **Customer complaints** | | | | | | | | |
| 41 Emotional responses to complaints | 137 | X | | | | | | |
| 42 Addressing customer complaints | 138 | X | | | | | | |
| 43 An exchange of letters | 140 | (X) | | X | | | | |
| 44 Hot shot | 145 | | | | | | X | |
| 45 Excuse me | 146 | | X | (X) | (X) | | (X) | |
| 46 Delay in billing | 147 | | | | | | | X |
| 47 Today's the day | 148 | | | | | | | X |
| 48 To refer or not to refer | 149 | | X | | | | | |
| 49 The extended visit | 156 | | | | | X | | |
| 50 The waiting game | 158 | | | | | X | | |
| 51 Service with a smile | 160 | | X | | | | | X |
| **Managing patient expectations** | | | | | | | | |
| 52 About patient expectations | 167 | X | | | | | | |
| 53 Great expectations | 168 | | X | X | X | | X | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| 54<br>See me now | 171 | | | | | X | | X |
| 55<br>Living in fear | 172 | | X | (X) | (X) | | (X) | |
| 56<br>Quick fix | 173 | | X | (X) | (X) | | (X) | |
| 57<br>Request for referral | 174 | | X | (X) | (X) | | | |
| 58<br>Ready, set, go | 175 | | X | X | (X) | | | |
| 59<br>A long explanation | 178 | | X | | | | | |
| 60<br>The magic pill | 182 | | X | (X) | (X) | | (X) | |
| 61<br>Just my luck | 185 | | X | | | | | |
| **Confidentiality and privacy issues** | | | | | | | | |
| 62<br>Confidentiality in health care settings | 191 | X | | | | | | |
| 63<br>A place for everything | 192 | X | | | | | | |
| 64<br>On the line | 195 | X | | | | | | |
| 65<br>The promise | 199 | | (X) | (X) | X | | (X) | |
| 66<br>Ms. Mouth | 200 | | | | | X | | X |
| 67<br>Pressure at home | 201 | (X) | | X | | | | |
| 68<br>The inquiring spouse | 202 | | X | (X) | (X) | | (X) | |
| 69<br>In plain sight | 203 | | | | | | | X |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| 70 Celebrity secrets | 204 | | X | | | X | | |
| 71 Sex in the city | 207 | (X) | X | | | | X | X |
| **Inter-cultural communication** | | | | | | | | |
| 72 Dispelling the myths | 217 | X | | | | | | |
| 73 Communication essentials for multicultural care | 220 | X | | | | | | |
| 74 The culturally friendly practice | 222 | X | | | | | | |
| 75 Coffee time | 224 | | | | | X | | X |
| 76 Professionally speaking | 225 | | | | | X | | |
| 77 Take my advice | 226 | X | | | | | | |
| 78 Traditional treatment | 227 | | X | (X) | (X) | | (X) | |
| 79 Hard labor | 231 | | X | X | X | | X | |
| 80 Invisible Differences | 234 | | X | X | X | | X | |
| **Coordination and consistency** | | | | | | | | |
| 81 An interesting paradox | 241 | X | | | | | | |
| 82 Enhancing coordination | 243 | X | | | | | | |
| 83 Refining referrals | 245 | | X | (X) | (X) | | (X) | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| 84 The shift change | 247 | | (X) | X | (X) | | (X) | |
| 85 Past and present | 251 | | X | (X) | (X) | | | |
| 86 Bewitching encounter | 253 | | X | X | | | | |
| 87 Dropping the ball | 256 | | X | | | | | |
| 88 Meeting madness | 258 | (X) | X | | | X | | |
| **Prevent/reduce medical errors** | | | | | | | | |
| 89 Root causes of medical errors | 263 | X | | | | | | |
| 90 Coping skills | 264 | | X | X | X | | X | |
| 91 Friend of the family | 265 | | X | X | | | | |
| 92 Mum's the word | 270 | | X | X | (X) | | (X) | |
| 93 Who's on first? | 271 | | (X) | (X) | X | | (X) | |
| 94 Is no news good news? | 272 | | X | (X) | (X) | | (X) | |
| 95 Two birds, one stone | 273 | | (X) | (X) | (X) | | (X) | X |
| 96 Hammer and nails | 274 | | X | | | | | |
| 97 Close call | 276 | | X | (X) | (X) | | (X) | |

| Title | Page | All | Physician | Nurse | Physician assistant | Administrator | Public health | Other |
|---|---|---|---|---|---|---|---|---|
| **Communicating with your community** | | | | | | | | |
| 98 Care coordination | 283 | X | | | | | | |
| 99 Building community partnerships | 284 | X | | | | | | |
| 100 Willing to serve | 287 | (X) | | | | | X | |
| 101 Out of the loop | 288 | X | | | | | | |
| 102 Lack of trust | 289 | | X | (X) | (X) | X | (X) | |
| 103 Competing practice | 290 | | X | | | | | |
| 104 The shy doc | 291 | | X | (X) | (X) | | (X) | |
| 105 Trouble in paradise | 292 | (X) | X | | | X | | X |

## Matrix 3: Exercises by time allotment

Note: A number in parentheses tells how many exercises are included in the specified training time.

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| **Effective listening** | | | | | | |
| 1 Practice in effective listening | 3 | | X | | | |
| 2 The look of listening | 6 | X | | | | |
| 3 Intro to listening | 7 | X | | | | |
| 4 Person-to-person | 8 | | X | | | |
| 5 20 questions | 12 | | | | X | |
| 6 Organizational listening | 17 | | | X | | |
| 7 Listening between the lines | 21 | X | | | | |
| 8 Are YOU a good listener? | 23 | | X | | | |
| 9 Faulty listening habits | 32 | | | X | | |
| 10 Excuse my back | 36 | | X | | | |
| 11 Getting the patient's story | 39 | | | X | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| 12 True confessions | 45 | | X | | | |
| 13 Behind closed doors | 50 | | | X | | |
| **Improving patient relationships** | | | | | | |
| 14 Effective patient relationships | 57 | X | | | | |
| 15 Patient relationships: what not to do | 58 | | X | | | |
| 16 Cool reception | 62 | | X | | | |
| 17 Between visits | 68 | X | | | | |
| 18 Anxious moments | 69 | | | | X | |
| 19 Lucky you | 74 | | X | | | |
| 20 Love me, love me not | 81 | | | X(2) | | |
| 21 Drama queen | 83 | | | X(2) | | |
| 22 The maddening patient | 84 | | | X(2) | | |
| 23 The worried well | 85 | | | X(2) | | |
| 24 Social hour | 86 | | | X(2) | | |
| 25 A personal matter | 87 | | X | | | |
| 26 No stupid questions | 90 | | X | | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| 27 Vague comfort | 93 | | X | | | |
| 28 Believe me | 96 | | X | | | |
| **Customer service strategies** | | | | | | |
| 29 Shaping perceptions | 103 | X | | | | |
| 30 Customer service needs | 104 | X | | | | |
| 31 In the patient's shoes | 105 | | X | | | |
| 32 Going the extra mile | 107 | | | | X | |
| 33 What would Disney do? | 113 | | | | X | |
| 34 And the winner is . . . | 116 | | X | | | |
| 35 Small world | 119 | | X | | | |
| 36 Point of no return | 121 | | X | | | |
| 37 The great escape | 123 | | X | | | |
| 38 The fall | 125 | | X | | | |
| 39 A pain in the neck | 128 | | X | | | |
| 40 From no to yes | 132 | | X | | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| **Customer complaints** | | | | | | |
| 41 Emotional responses to complaints | 137 | X | | | | |
| 42 Addressing customer complaints | 138 | X | | | | |
| 43 An exchange of letters | 140 | | X | | | |
| 44 Hot shot | 145 | | | X(2) | | |
| 45 Excuse me | 146 | | | X(2) | | |
| 46 Delay in billing | 147 | | | X(2) | | |
| 47 Today's the day | 148 | | | X(2) | | |
| 48 To refer or not to refer | 149 | | | | X | |
| 49 The extended visit | 156 | | X | | | |
| 50 The waiting game | 158 | | X | | | |
| 51 Service with a smile | 160 | | | X | | |
| **Managing patient expectations** | | | | | | |
| 52 About patient expectations | 167 | X | | | | |
| 53 Great expectations | 168 | X | | | | |
| 54 See me now | 171 | | X | | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| 55<br>Living in fear | 172 | | X | | | |
| 56<br>Quick fix | 173 | | X | | | |
| 57<br>Request for referral | 174 | | X | | | |
| 58<br>Ready, set, go | 175 | | X | | | |
| 59<br>A long explanation | 176 | | X | | | |
| 60<br>The magic pill | 182 | | X | | | |
| 61<br>Just my luck | 185 | | X | | | |
| **Confidentiality and privacy issues** | | | | | | |
| 62<br>Confidentiality in health care settings | 191 | X | | | | |
| 63<br>A place for everything | 192 | | X | | | |
| 64<br>On the line | 195 | | X | | | |
| 65<br>The promise | 199 | | | | X(3) | |
| 66<br>Ms. Mouth | 200 | | | | X(3) | |
| 67<br>Pressure at home | 201 | | | | X(3) | |
| 68<br>The inquiring spouse | 202 | | | | X(3) | |
| 69<br>In plain sight | 203 | | | | X(3) | |
| 70<br>Celebrity secrets | 204 | | | X | | |
| 71<br>Sex in the city | 207 | | | | | X |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| **Inter-cultural communication** | | | | | | |
| 72 Dispelling the myths | 217 | X | | | | |
| 73 Communication essentials for multicultural care | 220 | | X | | | |
| 74 The culturally friendly practice | 222 | | X | | | |
| 75 Coffee time | 224 | | | X(2) | | |
| 76 Professionally speaking | 225 | | | X(2) | | |
| 77 Take my advice | 226 | | | X(2) | | |
| 78 Traditional treatment | 227 | | | X(2) | | |
| 79 Hard labor | 231 | | | | X | |
| 80 Invisible differences | 234 | | | | X | |
| **Coordination and consistency** | | | | | | |
| 81 An interesting paradox | 241 | X | | | | |
| 82 Enhancing coordination | 243 | | | | | X |
| 83 Refining referrals | 245 | | X | | | |
| 84 The shift change | 247 | | | X | | |
| 85 Past and present | 251 | | X | | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| 86 Bewitching encounter | 253 | | X | | | |
| 87 Dropping the ball | 256 | | X | | | |
| 88 Meeting madness | 258 | | X | | | |
| **Prevent/reduce medical errors** | | | | | | |
| 89 Root causes of medical errors | 263 | X | | | | |
| 90 Coping skills | 264 | X | | | | |
| 91 Friend of the family | 265 | | X | | | |
| 92 Mum's the word | 270 | | | X(2) | | |
| 93 Who's on first? | 271 | | | X(2) | | |
| 94 Is no news good news? | 272 | | | X(2) | | |
| 95 Two birds, one stone | 273 | | | X(2) | | |
| 96 Hammer and nails | 274 | | X | | | |
| 97 Close call | 276 | | X | | | |
| **Communicating with your community** | | | | | | |
| 98 Care coordination | 283 | X | | | | |
| 99 Building community partnerships | 284 | | X | | | |

| Title | Page | 15 minutes | 30 minutes | 45 minutes | 60 minutes | 90 minutes |
|---|---|---|---|---|---|---|
| 100<br>Willing to serve | 287 | | X | | | |
| 101<br>Out of the loop | 288 | | X | | | |
| 102<br>Lack of trust | 289 | | X | | | |
| 103<br>Competing practice | 290 | | X | | | |
| 104<br>The shy doc | 291 | | X | | | |
| 105<br>Trouble in paradise | 292 | | | | | X |

## Suggested reading

### EFFECTIVE LISTENING


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