Compassionate Communication
Compelling Articles and Tools for the Healing Patient Experience
WELCOME patient care leaders and patient experience champions!

Do these challenges sound familiar?

- Delivering compassionate care when staff feel stressed and, at times, demoralized
- Ensuring patient safety
- Breaking through the wall on CAHPS scores
- Achieving and sustaining magnet designation
- Engaging hearts and minds of staff to provide superior care and feel gratified in their daily work

On behalf of the Language of Caring team, we are delighted to offer you this collection of articles and tools to invigorate your efforts to meet these challenges head-on and provide exceptional patient, family and staff experiences.

How You Can Use These Articles and Tools

- As a shot-in-the-arm and some fresh ideas for you personally
- As a one-topic-at-a-time focus for staff discussion and renewal
As food for thought, inspiration and help for your Patient Experience planning team

As a series of practical articles to circulate throughout your organization (e.g. in your newsletter)

…and more

We hope you find these articles and tools inspirational, concretely helpful, and supportive as you advance your commitment to employee engagement and patient-centered care.

Please don’t hesitate to reach out to us with questions or to learn how we can help you further.

Warm regards,

Jill Golde, Wendy Lebov and Dorothy Sisneros
Partners, Language of Caring

Find more tools and resources as well as information about Language of Caring programs and services at http://www.languageofcaring.com;
jgolde@languageofcaring.com;
wleebov@languageofcaring.com;
dsisneros@languageofcaring.com
About Language of Caring®

Language of Caring is a healthcare consulting firm led by Wendy Leebov, Jill Golde and Dorothy Sisneros. Driven by a passionate commitment to strengthen humanism in healthcare, Language of Caring helps healthcare organizations inspire exceptional experiences and communities of caring through compassionate, evidence-based communication. Language of Caring offers a rich array of leadership development and support services and skill-building programs for staff and physicians—all designed to enhance the patient, family and employee experience.

Our flagship program, Language of Caring for Staff®, is a proven strategy that helps staff speak the Language of Caring, so patients, families and coworkers feel their care and compassion and become more engaged, trusting, and less anxious. The results: an energized, gratified workforce, a stellar patient experience, improved safety, higher CAHPS scores, and better clinical outcomes.
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Clinicians need to make their caring commitment to their patients and families explicit in words as well as actions.

Motivated to serve their communities well and improve their satisfaction scores, hospitals and physicians are focusing on improving the patient experience. Many tackle the challenge by targeting one survey item at a time. For instance, if a hospital gets a low score on the question “How often do nurses do everything possible to help with my pain?” it might focus on better pain management.

Of course, the survey includes many questions, and focusing on one item at a time leads to a revolving door of strategies. I call this method—tackling one survey item after another—the shotgun approach. Certainly, hospitals have improved their performance this way, but the shotgun approach often proves overwhelming to the staff.

The other method I call the bowling approach. When you bowl, you aim for the sweet spot—the front pin, and when you hit it well, the other pins fall. So you aim at one improvement goal that will have an impact on many
others. You go after that one goal and you end up producing a positive impact on many others as well.

The Sweet Spot

Language of Caring has demonstrated that caring communication or, as we call it, “the Language of Caring,” is indeed the sweet spot for improving the patient and family experience. When you help physicians and staff build their skills in communicating their empathy and you inspire them to use these skills consistently to make their caring felt, scores improve on many survey items, even those that appear to have no connection.

Communicating caring is a single breakthrough objective with an enormous impact on the patient and family experience. It also strengthens physician and staff satisfaction, because it earns patient trust and cooperation and helps our care teams feel fulfillment from their caring work.

Why, You Might Ask, Is Caring Communication a Breakthrough Objective?

For more than 30 years, I’ve been helping health care organizations provide healing environments and healing communication for patients, families and everyone on the health care team. During these years, the only constant in health care has been change:

- a growing dependence on technology: computerized medical records; changing payment methods;
- changing consumer expectations;
- patient satisfaction scores on the Web for all to see; more paperwork;
- new regulations;
- downsizing;
- pressure to do more with less;
- much more.

For health care employees and physicians, these changes have been wrenching.

**Solving the Mystery**

A few years ago, a chief nursing officer friend called me with news that she had moved to a new organization where patient satisfaction scores were very disappointing. She couldn’t figure out why and she asked me to visit and see if I could shed any new light.

I wandered around. I slowed down in hallways so I could overhear conversations between nurses and patients. I shadowed a transporter to experience his interactions with patients. And I interviewed patients and their family members about their care experience.

To make a long story short, I saw very nice, competent, focused, busy caregivers going from task to task with deliberateness and competence. But there’s one thing I didn’t see: demonstrations of caring. People were primarily task-oriented—focused on their activities and their to-do lists. I saw shockingly little in the way of caring behaviors—personal connecting, empathy, handholding or warmth. I saw caregivers who undoubtedly were caring on the inside appear to be all business, impersonal or even detached on the outside. And my interviews with patients and families bore this out. Patients and families were touched by a select few caregivers but, more often than not, they were taken aback at the lack of personal connection and caring shown by members of the care team.
Expressing Empathy

It’s good to be caring by nature—caring on the inside—but if you don’t express it in your interactions with patients, families and coworkers, it’s as good as absent.

Example:

Patient: “I’m in terrible pain. I need more medicine now!”
Nurse: “Tell me more about the pain. Where is it exactly? And how would you rate your pain from 1 to 10?”

The nurse wants to address the patient’s need, but her response is entirely task-oriented, not caring. She is caring but isn’t making her caring felt.

A better example:

Patient: “I’m in terrible pain. I need more medicine now!”
Nurse: “I’m so sorry about your pain and I want to help! So, tell me more about it. Where is it exactly? And how would you rate it from 1 to 10? I want to ease your pain!”

Why better? Because in the second example, the nurse made certain to express her caring. And no doubt, the patient trusts that the nurse really wants to help!

People in health care are caring people. But their focus on the multitude of tasks, requirements and pressures causes this attribute to recede into the background. It needs to be expressed. And not only do we need to expect every member of the health care team to communicate their caring, we also need to help them strengthen the skills for making their caring felt.
The Red Thread

Scripting doesn’t cut it. Making your caring felt is something that needs to be like a red thread that you weave throughout all of your interactions. It affects the quality and effectiveness of everything else you do.

Take the common process of rounding—a powerful, evidence-based best practice. Why are so many leaders disappointed in their results from instituting hourly rounds by nurses? Because of the task-oriented way it’s sometimes implemented. A nurse can pop in and say “Need anything?” and check off that they have rounded. But rounding has powerful effects only if the nurse enters the room, tunes in to the patient fully, looks for clues about how the patient is feeling and what he or she needs, asks directly what will help the patient (using protocols such as the four P’s: pain, position, potty, possessions), then listens and responds with task-related actions and caring.

Hundreds of interactions occur between staff and patients from arrival to admissions:

- Transporter takes patient to room.
- Nurse greets patient, orients to room and takes history.
- Physician stops in to touch base.
- Physician or nurse explains care plan.
- Respiratory therapist coaches patient through breathing exercises.
- Housekeeper cleans room.
- Food service delivers dinner.
- Nurse holds discharge-planning conversations.
- Care manager makes follow-up phone calls.
- And many, many more.
The red thread needs to run through every spoken and unspoken conversation between caregiver and patient, 24/7.

Caring communication is the next big thing and needs to be an enduring focus for improving the patient and family experience.
Communication Is Not “Soft Stuff”

DOROTHY SISNEROS—HeartBeat, June 2016, Volume 7, Issue 90

Your organization’s investment in improving the patient experience through better communication will yield high returns. This has been proven time and again throughout health care. Caring communication leads to better patient experiences. This benefits your organization in multiple ways: patient loyalty, higher CAHPS performance, employee engagement, quality of work life, and improved clinical outcomes. Still, some people see communication as “soft stuff”—not to be taken as seriously as technological advances or financial bottom lines. However, a recent nationwide survey of acute care hospitals published in Management Science (https://www.researchgate.net/publication/269104709_The_Impact_of_Combining_Conformance_and_Experiential_Quality_on_Hospitals%27_Readmissions_and_Cost_Performance) and summarized in the Harvard Business Review (https://hbr.org/2015/09/what-has-the-biggest-impact-on-hospital-readmission-rates) finds that “caregivers’ ability to engage in meaningful communication with the patient” is an essential factor in reducing readmission rates. Further,
the survey concludes that, to produce a higher quality patient experience, investment in tools and techniques that foster “meaningful communication” is more cost-effective than purchasing technological devices that reduce response time.

In his book *How Doctors Think*, Jerome Groopman, M.D. documents the results of poor communication, from patients leaving healthcare services over a misunderstanding to misdiagnoses by doctors who don’t listen attentively to patients and family members.

There are financial results as well. Hospitals risk losing Medicare reimbursements if they don’t show improvement on HCAHPS scores for patient experience. Also, recent research finds that U.S. hospitals delivering a “superior” customer experience (as shown by HCAHPS scores) achieve net margins 50% higher than those hospitals that provide an “average” customer experience. According to the Healthcare Advisory Board, a healthcare organization could bring in millions of dollars of additional revenue if, by improving the experience, it encourages even a small percentage of patients to return rather than seek care elsewhere for their future healthcare needs. By improving the patient experience you lower the likelihood of expensive malpractice suits too, since these are triggered by anger resulting from poor communication more often than by physical harm. Dissatisfied patients spread the word about their negative experiences, resulting in loss of referrals. Also, a positive work environment and caring communication among staff helps retain employees—reducing the cost of hiring and training replacements.
Communication Is NOT The “Soft Stuff.”

Investment in communication skills should be understood as supporting—not competing with—our fundamental goal of providing excellent medical care. Clear and caring communication is not a luxury. It is part and parcel of quality health care. Spending money on flat screen TVs and stone fireplaces in the lobby, as some hospitals have done in an attempt to impress patients—that is the ‘soft stuff’, expensive and with little to no impact on patient outcomes or patient loyalty.

In contrast, the relatively modest cost in time and money needed to significantly improve physicians’ and staff members’ communication skills is proven to bring tangible results. It enables people to do their jobs better. Misunderstandings are avoided. Vital information is transmitted from patients and family members to caregivers. Patient loyalty and trust are built. Patients return to organizations that make them feel heard, understood, respected and cared for.

Beyond Soft Skills; Beyond Basic Skills

The skills that produce the kinds of breakthroughs described above are not soft. They are concrete, definable and learnable. And they go beyond basic skills. The skills that healthcare professionals need to strengthen are advanced skills… skills for communicating empathy, for listening open-mindedly and non-judgmentally in the face of stress and time pressure, for engaging patients, for facilitating joint decision-making, and for explaining so effectively that people fully absorb and process difficult information and life-changing messages.

The small percentage of physicians who resist communication skill-building because “we learned these skills in kindergarten” may be managing the basics just fine, but they are overlooking the power of advanced skills to achieve an exceptional patient experience and optimal health outcomes.
How to Build Advanced Communication Skills with Your Providers and Staff

1. Identify champions who realize the power of strengthening provider and staff communication skills. Engage them in evaluating alternative skill-building approaches and selecting those that are a best fit for the organization.

2. Take the time with champions to develop an elevator speech they can use to build openness and commitment to training among colleagues. Address:
   - The powerful influence of effective communication on patients and colleagues—on their engagement and partnership, and on safety, outcomes, ratings of care, malpractice and reputation.
   - The fact that communication skills required to create an exceptional patient experience are not soft skills, nor are they basic. They are definable and learnable and an advanced, beyond-the-basics skill set.

3. Create and implement a skill-building strategy that is powered to change behavior—a long-term, not one-shot strategy that includes defined competencies and requisite behaviors, illustrative behavioral modeling, team interaction for processing and practicing the skills, skill reminders, and opportunities for feedback and coaching.
Caregivers, May I Ask You?

AMY STEINBINDER—HeartBeat, April 2015 Volume 6, Issue 76

My father is elderly—nearly 87 years old. That doesn’t mean that he is incompetent, infirm or uninterested regarding decisions and information about his body, his health and his life. Yes, it does take him longer to process information. So I ask you:

- Can you please speak slowly and patiently wait for his response?

Yes, he is hard of hearing and he often misunderstands what you are requesting or saying. So I ask you:

- Can you please face him directly, annunciate clearly and project your voice?

- Can you focus on communicating to him rather than multitasking, looking down or looking away as your voice gets redirected from him to the floor or blood pressure cuff you may be using?
Also, since it is his body, his health and ultimately his decisions about the care he is receiving, I ask you:

- Can you please speak directly to him?

Yes, I am in the room and I am his advocate. I am there if and when he needs me to speak up. So I ask you:

- Can you please not assume that only I have the answers?
- Can you please not address questions to me?
- Can you please wait for him to either answer directly or look to me to give the information you are requesting?

Yes, he is unsteady on his feet. He does have a healthy fear of falling and he does move slowly. So I ask you:

- Can you please walk next to him at his pace so he isn’t reminded of how slow he is and doesn’t feel that he is lagging behind?

Yes, he does have many chronic conditions—heart disease, arthritis, back pain, asbestosis, and a neurological disorder that is robbing him of his short-term memory and causing his gait to become increasingly unsteady. Yes, he does have to use supplemental oxygen 24/7, he does take several medications to stabilize his blood pressure and his heart function, and he does need narcotic pain medications to reduce the constant pain he experiences. So I ask you:

- Can you please convey to him that despite all of the challenges that he faces every day that you admire him for his tenacity and his ability to keep moving forward?

Please recognize that he has experienced tremendous losses. You may not know about them all (significant ones - loss of his wife of 60 years, loss of his 25-year old son over 25 years ago, loss of his sister-in-law, brother-in-
law, aunts, uncles, cousins and many close friends), but I imagine that for any elderly man, loss is a significant part of life. So I ask you:

- Can you please ask him about his life, his family and the people who are important to him?

Yes, his purpose in life is rapidly changing. He no longer has his wife and children who depend on him. He no longer drives. He is unable to do his own cooking and take care of his home. He has transitioned from being totally independent to now being dependent on others. So I ask you:

- Can you listen intently and help him think about a new purpose for his life? We in his immediate family struggle with this and will appreciate any light you may be able to shine.

So, as I end my seemingly unending barrage of questions, I ask you one final question:

- How can you ease the burden, the confusion and the angst of your elderly patient who is my elderly father and use your voice, your ears and your heart to ease the transitional journey for him and for me?
Dear Nurse Executive

RHONDA WILLIAMS—Language of Caring blog, February 2017

I want to give you warm and heart-felt thanks for all you do every day. Doing the work of Angels is not easy but without you, patients and families could not experience the care necessary to heal. The work you do goes so far beyond what is obvious to the eye. As a former Nurse Executive, I understand how much of you is required to accomplish even small bits of progress in the midst of the major challenges you face.

Nursing is at the heart of hospital care and has a tremendous impact on patients, families and the entire healthcare team. If nursing is not performing optimally, every stakeholder feels it. In a society where many feel nursing is an under-appreciated profession, I want you to know you are valued and respected by so many both in and out of your organization.

Patients and Families

It goes without saying that patients and families are the reason we do what we do. They come to your hospital needing your services when they are in their most vulnerable state. They may be afraid, frustrated, or angry. While
you may not be privy to the past experiences that shape their perspectives, you understand that their feelings, symptoms, and perceptions result from something bigger. You stay focused on providing the unbiased and compassionate care they want and deserve. Please know for every ‘thank you’ received, there are probably hundreds more that patients and families did not express.

**Executive Team**

Your willingness and commitment to rise to challenges and high expectations is the difference between having a harmonious and high accountability team and a dysfunctional, ineffective team. You are the driver of alignment—and the glue that bonds and helps sustain alignment among many departments. You acknowledge the work to be done while advocating for your team so that they give and receive the respect and caring everyone deserves for their noble work and commitment to patients and each other. I cannot recall many meetings where the topic of “what nursing should be doing” did not arise. It can be exhausting and disheartening, making you wonder, “Do they understand how hard we are working.” Please know, even if it is not felt at that moment, the work by you and your team does not go unrecognized.

**Nursing Leaders**

All I can say to you is WOW! Your incredible leadership has the ability to touch lives and transform careers. You congratulate publically and coach privately. Your skillful navigation of the generational divide contributes to a cohesive team focused on the goal of providing each and every patient with an exceptional patient experience. But it does not stop there. You understand that team relationships, both interdepartmental and
intradepartmental, have a powerful impact on outcomes. You hold the team accountable for high expectations while fostering an environment that is blame-free and education-centric. Whether you offer a hug to the nurse who just experienced a personal loss or a high five and, of course, pizza when the team pulls through a challenging clinical situation, you do all you can do to be there for your team.

**Ancillary Departments**

In my early days as Nurse Executive, I remember feeling overwhelmed as each department shared what they needed from Nursing. It was so difficult to prioritize all of these needs. But you do! And, more importantly, you do it in a way that makes other department leaders feel valued and respected. Others leave conversations with you feeling pride in knowing you are the ultimate collaborator and, although your plate is full, you are always open to talk. You approach each situation with the big picture in mind. You know that every department is important to the exceptional patient experience. You embrace your role and lead the charge!

I could go on, but suffice it to say, your leadership helps transform organizations so that they replace tragic outcomes with consistently magic outcomes. Please know how incredibly valued you are, and thank you for doing the amazing work you do every day!
The POWer of Words

WENDY LEEBOV—HeartBeat, March 2013, Volume 5, Issue 2

I just came across an impressive study that reminded me of the dramatic power of words. The study reveals the difference in patient outcomes when a primary care physician asks, “Is there anything else concerning you?” versus “Is there something else concerning you?” Patients hear “anything else” as an attempt to close the encounter, while they hear “something else” as a door-opener to an unmet concern. The researchers found that the use of the word “some” instead of “any” eliminates more than three-quarters of all cases of unmet concerns! (Heritage, Robinson et al., Reducing Patients’ Unmet Concerns in Primary Care: The Difference One Word Can Make, J Gen Intern Med. 2007 October; 22(10): 1429–1433.)

This reminder of the power of words sent me to my files to locate my notes from a patient focus group I conducted a few years ago when I first became obsessed with defining the language of caring. I wanted to learn from patients and families about the words we use as healthcare professionals and their impact on patient and family feelings and behavior. I invited examples of words that create a negative impact—that are discouraging, insulting, annoying or otherwise trigger resistance or disengagement.
I also pumped for words we use that make patients and families feel good, motivated, cared about, cooperative and special.

**Words and Phrases with a Negative Impact**  
(I call these “Killer Words.”)

<table>
<thead>
<tr>
<th>You say</th>
<th>The patient or customer hears</th>
</tr>
</thead>
<tbody>
<tr>
<td>As soon as possible.</td>
<td>When I get around to it.</td>
</tr>
<tr>
<td>Hopefully...</td>
<td>Who really knows?</td>
</tr>
<tr>
<td>I’ll try.</td>
<td>Not sure I can do it. No promises here.</td>
</tr>
<tr>
<td>To be honest.</td>
<td>I was lying up until now.</td>
</tr>
<tr>
<td>I can’t do that.</td>
<td>I won’t do that.</td>
</tr>
<tr>
<td>It’s our policy. That’s against our policy.</td>
<td>That’s the way it is. Like it or lump it.</td>
</tr>
<tr>
<td>It’s over there.</td>
<td>I’m too important to show you the way.</td>
</tr>
<tr>
<td>You have to...</td>
<td>I’m in charge here. I made the rules and you follow them.</td>
</tr>
<tr>
<td>You must...</td>
<td></td>
</tr>
<tr>
<td>The truth is...</td>
<td>I probably shouldn’t tell you this.</td>
</tr>
<tr>
<td>Calm down.</td>
<td>You’re out of control and you’re the problem here.</td>
</tr>
<tr>
<td>That’s not my department, You’ll have to speak with someone else.</td>
<td>It’s not my problem and I won’t help.</td>
</tr>
<tr>
<td>If you read our policy...</td>
<td>Dummy.</td>
</tr>
<tr>
<td>If you had read the directions...</td>
<td></td>
</tr>
<tr>
<td>You should have...</td>
<td></td>
</tr>
<tr>
<td>Like I said...</td>
<td>You’re irritating me and wasting my time.</td>
</tr>
<tr>
<td>You can’t...</td>
<td>I set the rules here. You don’t.</td>
</tr>
<tr>
<td>What’s your problem?</td>
<td>Ugh, another demanding person!</td>
</tr>
<tr>
<td>Yes, but...</td>
<td>No.</td>
</tr>
</tbody>
</table>
Words and Phrases with a Positive Impact  
(I call these “Healing Words”)

<table>
<thead>
<tr>
<th>You say</th>
<th>The patient or customer hears</th>
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<tbody>
<tr>
<td>I can certainly help you.</td>
<td>I’m here for you, for sure.</td>
</tr>
<tr>
<td>I’ll gladly arrange that.</td>
<td>You can count on me to come through for you.</td>
</tr>
<tr>
<td>Delighted.</td>
<td>You’re not a bother at all. I’m here for you.</td>
</tr>
<tr>
<td>Absolutely.</td>
<td>You can’t count on me.</td>
</tr>
<tr>
<td>My pleasure.</td>
<td>It’s a joy to help you.</td>
</tr>
<tr>
<td>I’m happy to...</td>
<td>I love my job.</td>
</tr>
<tr>
<td>I’m really sorry...</td>
<td>I sincerely regret that you had an unfortunate experience.</td>
</tr>
<tr>
<td>Yes.</td>
<td>It’s clear. You can count on it.</td>
</tr>
<tr>
<td>What I can do is...</td>
<td>I really want to help somehow.</td>
</tr>
<tr>
<td>I’m asking you to...</td>
<td>I’d appreciate it if you would...</td>
</tr>
<tr>
<td>How may I help you?</td>
<td>Just say the word. I’m here to help.</td>
</tr>
<tr>
<td>Thank you so much.</td>
<td>I appreciate you.</td>
</tr>
<tr>
<td>I appreciate this.</td>
<td>I don’t take you for granted.</td>
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What Is Your Ratio of Positive to Negative Words?

Ask a coworker to audit YOUR words using this worksheet below and see how often you use positive, healing words, not negative or lackluster words, to elevate other people’s spirits, reduce their anxiety, and earn their trust and cooperation.

Every one of us has some degree of control over our effect on others. By choosing words that typically have a positive impact and using these words in a genuine, not forced or scripted way, we will more often than not create the impact we want. Good words work wonders.
**Word Hunt**

Dear Coworker,

You see and hear how I communicate. Please help me communicate better by making me aware of the words I use that, in your view, have a POSITIVE vs. NEGATIVE impact.

<table>
<thead>
<tr>
<th>Words with Positive Impact</th>
<th>Words with Negative Impact</th>
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Skills for Communicating Caring
Mindfulness helps everyone—patients, clinicians and administrators—to manage stress and achieve better results.

A boatload of simultaneous priorities, a multitasking frenzy, role overload, time constraints, financial pressures, racing minds, exhaustion and stress—these are realities in health care (and life) today. And they are killers. In health care, these realities are killers of quality, engagement, morale, Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, and the health and well-being of patients and families, health care leaders, physicians, and staff.

It would help to set priorities, to identify the select few objectives with the greatest impact and chase after them relentlessly. It would help to get better organized, add more staff, improve efficiency, learn to lead more effectively, hire more dynamos, engage process improvement teams, and lengthen each day by a few more hours. We’ve been trying to do all that without sufficient relief.
I propose a single, powerful approach that will help care providers and staff, patients and families all experience less stress and better results. The approach involves helping everyone—leaders, physicians, staff and patients alike, to master and use the skill of mindfulness. Mindfulness is transformative—for individuals and for organizations.

**Mindfulness and Its Benefits**

Mindfulness is the practice of focusing our attention purposely on the present moment and accepting it without judging. It is all about openly experiencing what is there. Mindfulness used to be considered a New Age skill, but no more. It has made its way into the mainstream, with everyone from kids to new mothers to physicians and CEOs recognizing its value and taking steps to make it habit.

In the personal realm, no matter what your role in life, mindfulness helps you engage fully in what you’re doing and what’s happening around you and within you. It helps you savor the pleasures and deal more effectively with adverse events. It stops you from worrying about the future or dwelling on regrets or negative past experiences. Also, it reduces rumination and stress. It boosts working memory. It helps you to focus your attention. It makes you less reactive and more reflective. It increases cognitive flexibility and creativity. And it improves relationships.

In health care specifically, mindfulness produces powerful benefits for leaders, staff, clinicians and patients alike:

Mindfulness offers significant benefits to executives. Imagine if you were to consistently practice mindfulness in your everyday work. You would focus fully on one major priority at a time. You would stop to reflect on what is actually happening in the present moment, how people are acting and reacting, what they’re experiencing, seeing, hearing and learning. You
would be plugged into the realities. You would tune into yourself and your inner wisdom, and you would experience others in a positive, open-minded and curious way. You would strengthen your focus and your relationships and make better decisions.

Mindfulness helps staff to create a positive and healing patient and family experience. When physicians and staff are mindful with patients and families, they notice cues and gain invaluable information that helps them to address concerns and provide safe and effective care. They feel more compassion and communicate with greater empathy. They ease patient and family anxieties, because patients and families feel their caring. They encourage patients and families to open up, to trust and to partner in their care.

As mindfulness expert Jon Kabat-Zinn says, only when we are mindful with patients will we release our innate compassion. He calls mindfulness “presence of the heart”. When caregivers really listen—in compassionate silence, taking in what’s happening, instead of trying to fix it, push it away, hurry out of the room, or contemplate the next pressing thing they have to do—this is deeply healing for the patient.

Mindfulness benefits physicians professionally. Ronald Epstein, M.D., and Michael Krasner, M.D., at the University of Rochester School of Medicine and Dentistry, have confirmed that mindfulness training for physicians has a powerful, positive impact on care decisions, patient perceptions of their doctor and physician job satisfaction. Physicians benefit from a stronger feeling of connection with their patients, greater patient satisfaction and retention, reduced stress, and professional pride in their positive impact.

Nurses benefit, too. Nurses deal night and day with high-stress, high-emotion situations. It’s not easy to stay focused and tuned in. Mindfulness is a de-stressor. It is an antidote to the rampant pressures that nurses experience, helping them to maintain inner resilience so they can be non-distracted, open, compassionate and receptive with patients, while taking care of themselves.
Also, according to a recent study of 3,000 hospitals by Press Ganey, the nurse communication factor on HCAHPS is the rising-tide metric. When scores improve, so do scores on other HCAHPS dimensions, including responsiveness of hospital staff, pain management and overall rating of the hospital. Organizations that implement training in the language of caring, which ought to include staff skill-building on mindfulness, can achieve substantial gains in top-box HCAHPS scores. And improved scores strengthen the hospital’s reputation and reduce financial risk under value-based purchasing.

The organization wins. If caregivers were to embrace mindfulness, we would see a revival in the doctor-patient relationship. We would see health care shift from fixing body parts to healing the whole person. Patients would engage, physicians would be more gratified, nurses would be less stressed and happier, and executives would be more focused and effective. The results: fewer errors, more accurate diagnoses, better patient outcomes, greater patient satisfaction, higher HCAHPS and Consumer Assessment of Healthcare Providers and Systems Clinician & Group scores, healthier and more fulfilled physicians and staff, reduced absenteeism, more physician and nurse retention, and even reduced costs.

With mindfulness, all partners on the health care team can enhance their effectiveness, their impact, and their own health and job satisfaction.

What About Mindfulness for Patients?

As we take steps to transition from a health care system that supports illness to one that advances wellness, we also should be educating and engaging patients and families to learn and practice mindfulness. There is a compelling evidence base that demonstrates the power of mindfulness to help people with chronic pain, anxiety, panic, gastrointestinal distress,
sleep problems, depression, psoriasis, fatigue, high blood pressure, headaches and improved immune function.

Mindfulness is critical to effective self-care and should be the No. 1 item on a patient’s post-discharge plan and lifelong wellness plan.

Here are four suggestions to advance mindful practice:

- Help people learn it. Initiate programs that help patients and staff learn this mental discipline. It is learnable and there are many resources and people available to help you shape the optimal approach.

- Make mindfulness a job expectation for staff. After all, it’s central to quality, safety, patient outcomes, stress management, wellness and the exceptional patient experience. Articulate in your service standards, job descriptions and competency-building processes the primacy of mindfulness in all interactions.

- Promote the six-second approach. Suggest that people (including you) start small and experience the energizing and calming impact of mindfulness. Invite people to focus on their breathing, pairing one deep, centering breath with a frequent, routine activity, such as every time you wash your hands or knock on a patient’s door. Stop. Center yourself with one deep breath, taking one second to inhale through the nose and five seconds to exhale through the mouth. Then, you can approach the patient with compassionate attention and respect.

- Start with you. You’ll benefit personally and be much more credible and effective making the case with those who provide care and service in your organization.
Transformation from the Inside Out

The Institute for Healthcare Improvement calls for transformation of the health care system in accord with the Triple Aim: improving the patient experience of care (including quality and satisfaction); improving the health of populations; reducing the per capita cost of health care.

We discuss changing delivery systems, models of care, incentives and many other external variables as possible solutions. It’s time to go internal. By adopting and promoting mindfulness, we can transform ourselves so we are more focused, reflective, resourceful, open, creative, efficient and resilient as we make tough decisions and tackle the backbreaking work of transforming the health care system.
Four Pointers on Nonverbal Communication

WENDY LEEBOV—*HeartBeat*, August 2009, Volume 1, Issue 8

I’ve been doing a lot of communication skill training recently and I’m repeatedly impressed by the impact of the nonverbal dynamics between staff and customers on rapport, trust and mutual respect. I’ve been privileged to observe many people’s nonverbal behavior as they try their hand at various everyday scenarios. And here’s what I see:

- Some people say the right thing, but their nonverbal behavior doesn’t support what they’re saying.
- Some staff respond to the content of what their customer is saying even when the patient’s nonverbal behaviors communicate a completely different message.
- When asked to help each other communicate better, most people focus on “what you can say that might be better,” not on opportunities to communicate better nonverbally.
These observations have prompted me to think more about how to make nonverbal communication work for us as we strive to create great patient/customer experiences.

I want to share four thoughts with you:

1. **If your verbal and nonverbal messages don’t match, people believe your nonverbal messages.** Picture this. You’re furious and with a scrunched up forehead and sharply bitter tone, you say, “I am NOT angry!” There will be no doubt in people’s minds that you are angry, despite saying you’re not. This point is at the heart of why use of great scripts or key words can fail miserably if people’s nonverbal behavior doesn’t support the key words. At a fast food chain, for instance, most employees say as they complete your order, “Have a good day.” Some of them say this while making eye contact and smiling, and that makes it believable. But others say it in a robotic or resentful tone, and that does not accomplish its purpose. In those situations, I want to say, “If you want me to have a good day, first tell your face.”

2. **If you don’t tune in to the nonverbal signals of the people you serve, you’ll miss really important information and respond in ways that appear insensitive or uncaring.** My sister Linda was having a lot of undiagnosed pain. Upon arriving one morning, her caregiver Debbie asked her, “How are you feeling today, Linda?” Linda answered with a pained expression and a defeated tone, “Fine!” If Debbie hadn’t noticed Linda’s nonverbal cues, she would have taken her words at face value and said exuberantly, “GREAT!” Debbie would have missed Linda’s real message entirely. Instead, Debbie noticed Linda’s expression and tone and believed these signals, not her words. So, even though Linda said, “I’m fine,” Debbie responded with empathy, saying, “You look really uncomfortable. I bet it’s really hard to have so much pain and not know what’s wrong.” These words of empathy connected Linda to Debbie and helped her to feel less alone.
One more thing: When Debbie is with Linda, Debbie really tunes in. She’s fully present to her. If you aren’t present to the person you’re with, you’re going to miss their signals entirely, be unable to meet their real needs and miss the chance to show your caring.

3. **People’s nonverbal signals are often not about you.** It is often the situation, not the person that triggers their negative nonverbal signals. Anxiety, stress, nervousness, fear, newness, pain—all of these cause patients and families to feel distress and show it in their nonverbal behavior. So, when the people you serve scowl, groan, harrumph, raise their eyebrows, use snapping tones, shake their heads, and clench their teeth, consider first that these are signs of their distress over their situation, not about you. Instead of taking it personally, cut people a break and use these as triggers for responding with empathy.

4. **One nonverbal communication guideline will protect you from appearing culturally insensitive.** While communication research has shown that some nonverbal behaviors are universally understood (e.g. expressions of happiness, sadness, fear, disgust, surprise and anger), the meaning of most other nonverbal behaviors depends on one’s culture. In some cultures:
   - Shaking the head sideways means you agree.
   - The thumbs-up gesture is considered rude.
   - Looking down and not making eye contact is considered respectful.
   - Standing close to someone while talking with them is considered an invasion of personal space.

So what can you do? After all, knowing the cultural meaning of thousands of nonverbal behaviors and many diverse cultures is utterly impossible, and even when you try to learn this, you risk stereotyping people and that can be offensive. There is a solution. Mirror the other person’s nonverbal...
behavior. Match your body language signals to theirs. If they look intense, you look intense. If they are speaking quickly, speed up your speaking pace. If they show a sense of urgency, then respond with a sense of urgency not only in your words but also in your body language and tone. If they back away from you, back away a bit yourself.

When you synchronize your body language with theirs, it’s affirming to the other person. They feel accepted and this builds rapport and trust.

**Remember: Nonverbal communication has an enormous impact. Your posture, tone, pace and face all give away your real meaning.**
“But I MEANT Well!”
How the Gap Between Intent and Impact Affects the Patient Experience

WENDY LEEBOV—HeartBeat, March 2014, Volume 6, Issue 63

I just returned from a visit with my ailing mother and sister. At 96, my mother is doing everything she can to preserve her dignity in the face of memory loss, disorientation, immobility, and scary fragility. My sister Linda just returned home after months in acute care, then rehab, then acute care again for multiple infections and complex conditions that won’t quit. Linda has survived comas and sepsis more than once. She has physical therapy daily so she can maintain her ability to take 5 steps—with painful, painstaking effort.

During my visit, my mother and sister talked at great length about their recent healthcare experiences. I listened with sadness, frustration and appreciation as I heard their mix of heart-sickening and heartwarming stories.

They talked mostly about caregiver behaviors… the behaviors that meant a lot to them and the behaviors that infuriated them.
Steeped in healthcare and awed by the care and service providers I have the privilege of meeting every day, I felt dismayed. I know that people in health care are caring people. So, it was maddening to hear about tidbits of behavior that masked their caring and left my mother and sister with the opposite impression.

Positive Intent—Negative Impact

I call this the Honey-Sweetheart-Dear Phenomenon. Here’s why. Many caregivers call patients and family members Honey, Sweetheart, Hun, Dear, and other so-called endearments. When asked why, they say they want to warm up the interaction, connect personally and show kindness. In other words, they mean well! Yet, more than 60% of people find these terms disrespectful, patronizing and overly familiar. Forty percent don’t mind, but 60% do! For that 60%, there is a harmful disconnect between the caregiver’s intent and the actual impact.

Fact

- People judge us by our words and actions, not by our intentions.
- Our words and actions are visible. Our intentions are not.
- If our words or actions offend, it doesn’t help to tell people we meant well.
- The damage is already done.
### Examples

<table>
<thead>
<tr>
<th>Words/Actions Described By Patient</th>
<th>The Caregiver’s Positive Intent</th>
<th>Negative Impact: Patient Perception</th>
</tr>
</thead>
<tbody>
<tr>
<td>She calls me Sweetheart.</td>
<td>I want to be friendly and personal with my patients. I want them to feel comfortable.</td>
<td>I feel demeaned and disrespected. Does she not know my NAME?</td>
</tr>
<tr>
<td>She looked at her watch while I was talking to her.</td>
<td>I want to give a gentle hint that I’m out of time, instead of having to make a big point of it and hurt the patient’s feelings.</td>
<td>She can’t wait to get away from me. I’m not as important as her other patients.</td>
</tr>
<tr>
<td>He typed on a laptop the whole time he was asking me questions.</td>
<td>It’s efficient; it saves time. And, I capture the patient’s responses accurately.</td>
<td>He’s rude and he’s not really listening to me.</td>
</tr>
<tr>
<td>She was chewing gum with her mouth open and leaned over me. I could smell the gum and see down her throat. It was disgusting.</td>
<td>I’m a smoker and I don’t want my patients to smell tobacco on my breath. Also, chewing gum helps me with stress.</td>
<td>It’s so unprofessional and inconsiderate. It makes me sick.</td>
</tr>
<tr>
<td>Everyone asks me my birthdate.</td>
<td>We follow a strict protocol for the patient’s safety.</td>
<td>Is that a senility test? Do they think I’ve lost my mind?</td>
</tr>
<tr>
<td>She says “we” instead of “I,” like when she says, “Are we ready for our bath?”</td>
<td>Be friendly and personal. Connect with the person.</td>
<td>I HATE it when people say “we” instead of “I.” WE are not ready for a bath. I am. “Are we ready to eat? Are we ready to work hard in therapy? Are we ready to go home?” It’s so condescending and infantilizing; I could scream!</td>
</tr>
<tr>
<td>She told me, “Calm down!”</td>
<td>She was all riled up. I wanted to help her relax.</td>
<td>She thought I was overreacting! She has no idea what my life is like right now! It was dismissive. She just wanted me to shut up.</td>
</tr>
<tr>
<td>She wore a strong perfume.</td>
<td>I wanted to smell nice for my patients.</td>
<td>The smell made me sick to my stomach. There’s no way to turn off my nose.</td>
</tr>
<tr>
<td>“Sorry it took me so long. We’re short-staffed.”</td>
<td>I wanted to apologize for the delay and make sure she knew I was busy with another patient, not just taking my good old time.</td>
<td>Get me out of here. They aren’t equipped to take good care of me.</td>
</tr>
</tbody>
</table>
How Can You Make Sure that Your Impact Is in Line with Your Intent?

1. **State your intent before you act.** Check to make sure that what you intend is indeed valued by the person on the receiving end. If people realize your intent is in their best interest, they will accept your action and sometimes even help. If they don’t want what you intend, they’ll speak up and you can explain further or change course. Example:
   
   - Instead of closing a patient’s curtain without saying anything, ask permission or at least state your intent, giving the person a chance to say NO. E.g. “I’m going to close this curtain. I want you to have some privacy.” Patient replies, “No! I’d rather have it open.” You reply, “Okay, that’s fine. I’ll be glad to keep it open for you.”

2. **If a behavior might affect some people negatively and an alternative behavior would not, stop doing it.** E.g. perfume, gum-chewing, calling people Honey or Sweetheart.

3. **Listen and apologize.** When you become aware of your negative impact (because the person or a coworker tells you), first apologize. And then, learn more about their perspective. Invite their thoughts on how you should behave differently.

4. **Reflect and do better.** Ask yourself:
   
   - What just occurred?
   - How was the impact different from what I intended?
   - How do I fix this for the future? Take responsibility for the harmful impact, and stop doing the behavior.

5. **Raise your own and your team’s awareness about Intent versus Impact.** Below are two Practice Exercises to help you and your team become more alert to mismatches between intent and impact: Have leaders and your team practice and then commit to telling each other when you witness a mismatch using these two tools.
## Intent Versus Impact: Practice for Leaders

How can a leader’s well-intended behavior create an untended negative impact?

<table>
<thead>
<tr>
<th>Leader’s behavior</th>
<th>Positive intention</th>
<th>Likely employee perception</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>A manager schedules regular staff meetings and then often cancels them.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An employee asks her manager if she has time to discuss a concern. Her manager says, “Yes, definitely.” As the employee tells her story, the manager looks at her watch.</td>
<td></td>
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<tr>
<td>At a recent leadership meeting, managers learned about a difficult challenge the organization is facing. Later that day, an employee asked his manager, “Any news from the managers’ meeting?” The manager replied, “Nothing new, really.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A seasoned manager is having lunch with a new manager to help orient her. The seasoned manager has a good feeling about this new person, so he decides to alert her to the other managers who can’t be trusted.</td>
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</tr>
</tbody>
</table>

### A look in the mirror

Ask yourself: What well-intentioned behaviors on your part do you suspect might be having a negative impact on your staff?

1. ____________________________________________________________________________

2. ____________________________________________________________________________
## Intent Versus Impact: Team Practice

<table>
<thead>
<tr>
<th>Words/actions</th>
<th>The staff member’s positive intent</th>
<th>Possible negative impact on patient</th>
<th>What words or actions would match the intent?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop worrying. You’ll be fine!</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’m sorry I took so long. We’re short-staffed.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I’d like to do that for you help, but it’s not my job.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The doctor will see you shortly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speak extra-loudly to patients who are elderly or don’t speak English.</td>
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</tbody>
</table>

### A look in the mirror

Ask yourself: What well-intentioned behaviors on your part do you suspect might be having a negative impact on those you serve?

1. ______________________________________________________________________

2. ______________________________________________________________________
The Bottom Line

Of course, you mean well. Yet, it’s the impact of your behavior that people live with. For the sake of my mother and sister and everyone who depends on us to provide high quality, respectful care and service, make sure your behavior expresses your good intentions.
What Empathy Is Not!

WENDY LEEBOV—HeartBeat, October 2016, Volume 7, Issue 94

“The hearing that is only in the ears is one thing. The hearing of understanding is another. But the hearing of the spirit is not limited to any one faculty, to the ear or the mind. Hence it demands emptiness of all of the faculties. And when the faculties are empty, the whole being listens. There is then a direct grasp of what is right there before you that can never be heard with the ear or understood with the mind.”

Chuang-Tzu

We know that empathy is good for patients. It engenders trust, which increases patient comfort, reduces anxiety, fosters engagement, and leads to more positive health outcomes. When physicians are empathic, patients feel a connection or common ground and their recovery rates improve. Empathy is also good for providers. It helps doctors do their jobs well and reduce their own disillusionment and burnout. And empathy among members of the care team builds relationships and strengthens collaboration.
Often We Think We’re Being Empathic, but We Aren’t

Most of us learned to listen with our minds. We think about how to respond or how to fix the problem or what this reminds us of in our own lives. When we listen with our minds, we are not in the moment and we are not really connecting with the other person. Empathy involves mindful questioning, curiosity and wondering about the other person’s experience— connecting at a deeper level.

**Situation: Your coworker says, “My boss expects the impossible!”**

Below are typical responses, NONE of which are empathy. I’m not saying they are inappropriate responses. I’m just saying they are not empathy.

<table>
<thead>
<tr>
<th>Not empathy</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sympathizing</td>
<td>“I hate your boss for doing that.”</td>
</tr>
<tr>
<td>One-Upping</td>
<td>“You think you have it hard. If I’m not stressed out, my boss thinks I don’t have enough to do! I remember a time when my boss...”</td>
</tr>
<tr>
<td>Fixing</td>
<td>“I think you should tactfully confront your boss. I could help you practice.”</td>
</tr>
<tr>
<td>Therapizing</td>
<td>“I think you’re overreacting. Everyone’s under pressure, but you have a ‘poor me’ attitude.”</td>
</tr>
<tr>
<td>Advising</td>
<td>“Did you ever read the book Games Mother Never Taught You? You should read that. And you might also go to Human Resources about your boss.”</td>
</tr>
<tr>
<td>Discounting</td>
<td>“Hey, that’s par for the course when you have a boss. And anyway, you get a lot done, so maybe those high expectations work!”</td>
</tr>
<tr>
<td>Minimizing</td>
<td>“You’re a big boy. You’ll get over it.”</td>
</tr>
<tr>
<td>Interrogating</td>
<td>“What’s he expecting of you that you feel is unfair? Is there a pattern here?”</td>
</tr>
<tr>
<td>Analyzing</td>
<td>“You seem to overreact to what are normal pressures at work. Have you had a problem in the past with people who expected too much, like your parents?”</td>
</tr>
<tr>
<td>Defending</td>
<td>“Look, he’s under terrible pressure to produce for HIS boss! It’s not easy to be a boss with so much responsibility. Believe me, I know.”</td>
</tr>
<tr>
<td>Pollyanna-izing</td>
<td>“It feels bad now, but it will ease up. You’ve felt that way before and it always gets better.”</td>
</tr>
</tbody>
</table>
Feeling empathy involves tuning in eyes, ears, heart and soul—to really hear a person’s feelings and needs. Expressing empathy involves acknowledging these needs and feelings through words and nonverbal behavior. In the situation above, empathic responses sound like this:

- “You sound so frustrated. Are you?”
- “It sounds like a really stressful time for you.”
- “I’m so sorry you’re going through this.”
- “I feel for you. It sounds maddening.”

From Habitual Responding to Intentional Empathy

Many of us have habitual ways of responding that kick in when patients or colleagues reveal feelings, complain or express needs. See if you notice yourself using any of the “non-empathic” forms of responding. The challenge is to take a breath and CHOOSE how to respond when we want to show our empathy. Perhaps begin with the simplest form of empathy: asking “Are you feeling __________?” The result: connecting at a deeper level, learning more and having a stronger basis for helping going forward.
How valuable are the words I’m sorry? It depends who you ask.

- Some employees say, “I’m sick and tired of apologizing for things that aren’t my fault, like long waits, cold food, and lost information. I spend my whole day saying, “I’m sorry.”

- Some physicians say, “I don’t dare say I’m sorry because that implies that I’m guilty of something and I’ll get sued!”

- Some patients and families say, “SORRY isn’t good enough. I want you to fix the problem and prevent it for others in the future!”

These sentiments call into question just how effective it is to say “I’m sorry” when a patient, family member, physician or coworker is upset, frustrated, uncomfortable or otherwise dissatisfied.

I have strong feelings about this. I think it’s very important. Before explaining why, I want to respond to the sentiments described above.
To those employees who say, “I’m sick and tired of apologizing for things that aren’t my fault, like long waits, cold food, and lost information. I spend my whole day saying I’m sorry:” I realize it’s exhausting and demoralizing to be on the frontline—fielding repeated complaints when you don’t have the power to address the root cause and may be annoyed that higher-ups don’t use their power and resources to tackle the problem at its root, thus preventing it for a multitude of patients. I hope you’re speaking up with leaders about your frustration and sharing suggestions about solutions. If you have spoken up and no one appears to be listening, that is really maddening. Short of seeking another job if you are too demoralized from this, I still suggest that you use the “blameless apology” technique to show your sincere regret that your customer is not happy without either taking responsibility for the problem (as if you had caused it) or blaming anyone else. This is how you will get the best result in the interaction with your customer, relieve their stress AND YOURS because more often than not, the customer will realize that YOU are a caring person and genuinely regret their unhappiness. And, you can walk away with self-respect knowing that you have taken the high road—showing respect for the customer without showing disrespect for leaders in your organization.

To those physicians who say, ”I don’t dare say I’m sorry because that implies that I’m guilty and I’ll get sued”: I can certainly understand wanting to avoid lawsuits. The fact is, apologizing doesn’t bring on lawsuits. It prevents them! There’s old and new research that says the “deny and defend” malpractice culture is not effective. What works better? Read about the new research from the University of Michigan Health System, http://uofmhealth.org/news/archhive/2012/doing-right-thing-with-things-go-wrong And see “How to apologize for adverse events” at http://www.fiercehealthcare.com/story/how-apologize-adverse-events/2012-06-15?utm_medium=nl&utm_source=internal. This describes the “disclosure,
apology and offer” program being tested at Beth Israel Deaconess, Mass General and Baystate Health.

To those patients and families who say, “SORRY isn’t good enough. I want you to FIX the problem and prevent it for others in the future!” I couldn’t agree more. We apologize because we sincerely regret doing anything with a negative impact on you. AND, we know this is not enough—that we need to action to remedy the situation for you (if possible) and prevent it for others in the future.

The words I’m sorry are magic words IF they are used appropriately and effectively.

**Tips for Effective “I’m Sorry” Statements**

1. **Check your defensiveness at the door.** You can express sincere regret to another person who is having a negative experience even if you had absolutely nothing to do with it. “I’m so sorry this has been so upsetting for you.” Adopt and communicate an attitude of caring.

2. **Get specific.** If you only say, “I’m sorry” without saying what you’re sorry about, the person on the receiving end doesn’t realize that you have understood and responded with empathy. Include in your statement what exactly you’re sorry about. Otherwise, “I’m sorry” is nothing more than a throwaway line.

3. **Make it all about the other person, not about you:** What you’re sorry about needs to be all about the other person’s experience, not yours. “I’m sorry I’m late” is much less effective than “I’m so sorry you’ve had to wait for me.” Also, if you say you’re sorry about something you did without acknowledging its impact on the other person, the other person doesn’t realize that you were sorry about their experience.
4. **Synch your nonverbal behavior with your words:** There are so many ways to say, “I’m sorry!” You can say “So-o-o-o-rry” in a sarcastic way. You can say it in a flat tone, as if to say you aren’t sorry at all. Or you can say it with sincerity in your tone, face and eyes.

5. **Show your caring without blaming others or denying that you were responsible.**

- “I’m sorry, but it wasn’t my fault.” This sounds defensive.
- “I’m sorry you were inconvenienced. That doctor is always late.” This makes a colleague and your organization look bad. If you’re frustrated with someone for causing the problem, speak to them privately.
- “I’m sorry we’re short-staffed.” This doesn’t name a responsible party, but it implies that your organization is poorly managed… and that blames senior leaders (and causes the person to lose confidence in your entire team, including you.
- When it comes to blame, just don’t go there.

6. **Go beyond “I’m sorry.”** In the face of a complaint, look into the issue. Explore solutions. Offer remedies. Follow through. Report back your findings. “I’m sorry is not enough when it’s possible to do something to relieve the situation for this person and others in the future.
Engaging Patients and Families as Partners
“No Decisions About Me Without Me!”

WENDY LEEBOV—HeartBeat, May 2010, Volume 2, Issue 5

Harvey Picker, founder of the Picker Institute, coined this phrase many years ago. In my view, it articulates so simply and powerfully the key principle driving patient and family-centered care.

It’s exciting to see the epidemic of commitment to patient and family-centered care! The words ‘patient-centered’, ‘engagement’ and ‘partnership’ are everywhere, as are bulleted lists of key principles, factors and dimensions.

Since I’m very concrete, to better understand and embrace these concepts, I’ve been reflecting on personal experiences that make these concepts come alive. In some of these experiences, these concepts were glaringly missing and the impact was profound and disturbing. In other instances, these principles were in full bloom and the impact was profound and gratifying.

About Linda: My sister was deathly ill and in a coma in an ICU for several months. My mother and I did a vigil by her bedside. It was hard to hear
the caregivers talk around Linda, as if she weren’t there. To caregivers, Linda was a bedridden body with wires connected to every orifice. It hit me that caregivers didn’t talk to her much. And when they referred to her, they called her “she”, not “Linda”. It pained me that they couldn’t see the person within the patient. It was upsetting.

That night, I made a big poster called “About Linda”. I listed her passions: her legal specialties, her favorite charities, her fabulous cooking, the fact that she was a Marvin Hamlisch groupie, and her excitement about soon becoming a grandmother for the first time. And I taped on some photos of Linda dressed to the teeth. The next day, I hung this poster on the wall near her bed. Lo and behold, as caregivers entered the room, they couldn’t help but notice the poster and read it. Then, they immediately started talking to Linda and calling her by her name. They related to her in a personal way. It was such a relief for my mother and me.

Personalized care and engagement? Why don’t caregivers routinely interview the patient (and if not the patient, then their family) to find out about the patient as a person? The care will be better—patient centered. The family will feel less anxious and more trusting. How can we provide “patient-centered” care if we know nothing about the patient?

About Eddie: My brother-in-law Eddie is in the hospital as we speak—plagued by a recurrence of a severe leg infection. The pain is debilitating and his biggest concern.

Eddie is also intent on going home ASAP and asks every doctor and nurse, “When?” Doctors come and go at unpredictable times, and Eddie (like many heavily medicated people) isn’t so great at remembering the details of what the doctors say. My sister, central in decisions that Eddie faces, NEVER KNOWS WHEN THE PHYSICIAN WILL SHOW UP. And unless she is sitting there, she has no idea what’s going on. So, my sister has to chase down the doctor for a cursory report about Eddie while the doctor is on the run.
Patient-centered, partnership and engagement? Why don’t caregivers post on the whiteboard the main ongoing concerns preoccupying Eddie and Linda?

**Concerns:**
- Pain
- Going home
- Keeping his family informed

Then, doctors and nurses can PROACTIVELY ask Eddie about his pain, acknowledge and address his desire to go home, and check to make sure his family has up-to-date information about Eddie’s condition and options.

“Hi Eddie, how’s the pain this morning?” “I realize you’re really eager to go home. There are options for how you can receive your IV medication. Let’s talk about the pros and cons and see what you think. OK?” “I’m sorry I missed your wife this morning, and I know you want to be sure she’s in the loop about your condition and options. I’ll be back at around 4 this afternoon in case she wants to be here. Or, I’ll ask my assistant to set a time for a short phone call with her. Will that work?”

The concerns of the patient and family would be addressed repeatedly and proactively by the care team. How can we provide patient-centered care if we don’t solicit and proactively address the patient and family’s main concerns?

**About My Dad:** My dad, may he rest in peace, was in a nursing home with 24-hour care for six long months before he died. He had brain atrophy and was highly agitated and miserable—aware but completely unable to control his behavior. Needless to say, my mother, sister and I were distraught beyond words when various medications failed to comfort my
dad. We were a VERY upset family—for weeks and months. The nursing staff largely ignored us because of my dad’s 24-hour care (which they required). Then, one day, the head of nursing stopped in and asked to meet with me. When I went to her office at the appointed time, I thought maybe she would acknowledge what we were going through and provide some understanding or wise counsel about coping. Instead, she said, “I know your family is having a very hard time watching your father. I just want you to know that if any of you do anything to end his life prematurely, it will be treated as a criminal act.” I sat there stunned, dizzy and speechless. And then I walked out.

Two days later, my dad’s swallowing reflex failed and we were told that the doctor would be inserting a feeding tube. My mother was distraught. My parents had discussed end-of-life options and my dad had been vehement that he did not want to live on when he no longer had quality of life. After a family meeting and long talk with our rabbi, my mother decided that she did NOT want the feeding tube inserted. I told the appropriate people. And the head of nursing came in (only the second time in six months) to say that she thought we should realize that without the feeding tube, my father would “starve.” My mother collapsed. “Am I doing the right thing? Am I starving your father?”

Patient and family-centered care, supportive communication, respect for family wishes, partnership with patients and families? Good grief, no.

One Last Story: I’m a 12-year, 11 months and 6 day breast cancer survivor. When I was first diagnosed, I read everything you can imagine about breast cancer and options. I was glued to the Internet. I read about herbs and juicers and exotic miracle remedies in Mexico. I was drowning in information. I wanted to be sure I was doing EVERYTHING possible to improve my life chances. Everything. One day, after patiently inviting my questions and addressing them, my surgeon said, “Wendy, I know you
want to do everything you can to survive this. And I personally aim to make a toast at your hundredth birthday party. I respect your aggressive search for everything that can help you, and in fact, I’ve learned a lot by looking into your questions. At this point, I’m concerned that you may be overwhelming yourself with options and information and becoming even more anxious. I’m wondering, at this point, would you consider trusting me and the others on your care team to look out for your best interests and guide you, so you can turn your attention to taking the best possible care of yourself? I sighed with relief and this ended my frantic searching and enabled me to shift my attention to making the most of my get-well plan.

Respect, caring communication, partnership? Yes.

**Patient and family-centered care.** As we study it and try to make it happen, reflect on your own experiences with yourself and your family and concretely connect to the lofty words that describe a commitment whose time has come.
Patients, Please CUS at Me Any Time!

JILL GOLDE—HeartBeat, July 2011, Volume 3, Issue 7

Whoa, what you’re thinking is not what I meant. When I say I want patients to CUS at me any time I mean I want them to feel very free to say:

- I’m Concerned.
- I’m Uncomfortable.
- I’m Scared.

Many organizations have used the “CUS” model as a shared language for staff to use to express their level of disagreement or discomfort with an action or inaction affecting patient safety. It’s an assertiveness model. Staff who have a safety concern are advised to first say, “I have a concern”—for instance to a physician. Then, if the physician doesn’t listen or address the concern, the staff member is advised to step up their assertiveness a notch by saying, “I’m uncomfortable that…” Uncomfortable is a stronger word. Then, if the person still doesn’t listen or address the issue, staff are advised to step up their behavior yet another notch by saying, “I’m scared…” With
everyone using the same words, these words become code words, red flags, shorthand or alerts that come to mean, “Stop and listen to me! I see a threat to patient safety.”

CUS in Action
Billy Evans is a 4-year old patient with a history of juvenile diabetes. After a recent episode he was admitted to the pediatric unit. Although the lab showed his blood sugar as nearly under control, he was being held for observation until his vitals were normal. His nurse Joanne is preparing his injection. Another nurse, Bonnie approaches her:
Bonnie: “Joanne, that injection looks awfully large and the vial is a different color than his other injections. How much insulin are you preparing to give Billy?”
Joanne: “5 cc’s.”
Bonnie: “I’m concerned that we may be giving him too much insulin.”
Joanne: “Why do you think that?”
Bonnie: “Well, we usually give adult diabetics 5 cc’s. But he’s a kid a small child.”
Joanne: “You could be right. I’m new to Peds and not that familiar with kids.”
Bonnie: “This is a SAFETY issue and I really need you to stop what you’re doing and double check the orders more closely.”
Joanne puts down the syringe and hurries over to consult the chart, while Bonnie looks for the right vial. They both want what is best for Billy. Bonnie took it upon herself to voice her concerns and possibly prevented the death of a little boy.

While I love the CUS model as a shared language for speaking up about safety concerns, I also think the CUS model has great application in encouraging patients to speak up, so we can address their concerns and needs.
I was meandering around a nursing unit recently doing an informal assessment for my CNO friend to help her consider how her nurses could break through the wall on maddeningly stuck survey scores. She gave me carte blanche to shadow nurses, wander around, talk to people and see what I could learn.

Since the nurses had implemented what they described as a consistent system of purposeful rounding, I asked to follow a couple of nurses on their rounds for a few minutes to see what I could see. These nurses were obviously kind and very attentive to the patients’ needs. The nurses asked their 4P questions, addressed the patients’ needs, asked if there was anything else they could do for the patient, said a nice goodbye and left.

You might be thinking—sounds good. And you might be wishing that all of your nurse colleagues were doing as well as that. And I would see your point. But I was struck by how one-sided the communication was. The nurses asked their 4P questions. The patient answered with one-word answers. The nurse did what s/he had to do and left. In no case did any unpredictable need emerge from the patient. And what struck me most was how little two-way conversation there was and how noticeably absent was any emotional content from either the patient or the nurse. I thought to myself, “WOW, now I see why scores are so relatively low on ‘emotional support’ and ‘how well my nurse really listened to me’!”

**So What?**

I believe we can make hourly rounding much more powerful if we encouraged patients to CUS at us—to tell us:

- I’m concerned.
- I’m uncomfortable.
- I feel scared.
Then, we could inquire, listen, show caring and do all we can to address their emotional needs, not only their physical comfort needs. We need to proactively open the door to conversation about the patient’s emotions.

**How Can We Get Our Patients to CUS at Us?**

When we orient the patient, we can TELL the patient that we care about their emotional well-being and peace of mind. We can ENCOURAGE them to CUS at us. We can explain CUS and we can give them a notepad so they can jot down CUS notes to help them speak their minds when we check in on them.

**Please speak up so we can help you**

We want to do all we can to ease your anxiety and keep you comfortable. Please jot down notes to help you share your feelings or raise any concerns when we make our rounds.

“I’m concerned.”

“I’m uncomfortable.”

“I feel scared.”

We can build into our rounding protocols open-ended questions about CUS:

- “Tell me, what concerns are you having? If you’re feeling concerned, please tell me.”
- “I want you to be as comfortable as possible. Tell me, are you uncomfortable in any way—about anything? Please tell me.”
“I want to do all I can to ease your mind. Is there anything you feel anxious about? Please tell me.”

And we can add “Emotional Issues and Concerns” to the processes we use to verify completion of rounding and jot down notes on what we learned about the patient’s emotions during the round and what we did about it, if appropriate.

By inviting the patient to CUS at us—to share their feelings, we can listen, acknowledge their feelings and address them, helping our patients feel less anxious, more confident and secure in our caring hands.

**Note:** I first learned of CUS from Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. *Qual Saf Health Care.* 2004;13(suppl 1):i85-i90.
Challenging Situations
Dealing with Difficult-for-Me People

WENDY LEEBOV—Health and Hospitals On-Line, 2009

Showing a little compassion can greatly ease an otherwise difficult patient-caregiver relationship.

I feel sick at heart for the many wonderful, caring and compassionate health care professionals who feel demoralized by patients, families and colleagues they find difficult.

I admit, some people are truly difficult, but not nearly as many as we might think. Having spent the better part of four months visiting my sister in a variety of health care settings, I think many difficult people are not inherently difficult. They are made to be difficult.

Thankfully, my sister just returned home after care via ambulance, emergency room, intensive care, critical care, radiology, same-day surgery, long-term acute care, cath lab, cardiac care, rehab, primary care and now home health. No one in the ER or intensive care found my sister difficult. I would hope not, since she was unconscious in those settings. But after
my feisty sister defied all odds and regained consciousness, she gained a reputation as a difficult patient, and this reputation accompanied her to each new level of care.

My Sister Difficult? No.

She was hooked up to a ventilator through her mouth and later her neck, to a feeding tube, a central line, catheters, and to all kinds of monitors and had gizmos on her legs to enhance circulation. On top of that, she was placed in restraints for her own good so she wouldn’t dislodge any of these paraphernalia. Every orifice was invaded. For another month, she could not move, let alone walk, breathe on her own, talk or write. The call bell was her one-and-only communication device. And when she pushed that button, she wanted a response.

When she started to talk and asked, “When?” she was told, “Soon. You’re not our only patient.” When she asked, “Why not?” she was too often told, “It’s against policy.” When she asked, “How can I possibly do that?” she was told, “Toughen up, honey.”

Time and again, she felt upset. A diplomat at heart, she complained nicely at first. But after a series of unresponsive indignities, she fought sleep because she was so afraid of what would happen if she took a rest from being vigilant on her own behalf. She became impatient and irritable, and she issued demands. What started as “Will you please ___________?” turned into “I want it and I want it NOW!” In her desperation, the time for politeness had ended because politeness was not working.

My sister felt desperate and out of control of her body and her life. That, combined with predictable ICU psychosis, led her to behave in ways that some caregivers found maddeningly stressful.
It doesn’t have to be that way. Without question, our health care colleagues mean well. The amazing clinical care my sister received takes my breath away. It saved her life. The people who choose health care professions care! They want what’s best for people. And because they know they mean well, they feel affronted by patients and families who don’t seem to appreciate that.

**Showing Our Caring**

*If patients don’t see caring, for them it isn’t there.* The problem is not a lack of caring. The problem is a lack of showing it. We need to do and say things that make our caring and commitment to patients glaringly obvious.

This five-point plan goes a long way toward reducing the number of (and angst created by) difficult-for-me patients:

**Reduce Difficult-for-Me Patients: a Five-Point Plan**

1. Stop allowing bits of behavior that many patients find irritating.
2. Coach staff to express caring out loud—with words that reflect empathy.
3. Help staff stop taking demands, impatience, frustration and pain as defiance or personal insults.
4. Institute regular processes that prevent desperation.
5. Build staff communication skills by focusing on the difficult situations that deplete their energy.
Point 1: Stop allowing bits of behavior that many patients find irritating.

Some staff do things that predictably come back to haunt them. Here are a few examples.

<table>
<thead>
<tr>
<th>Irritating to Patients</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do the tasks; express no compassion.</td>
<td>If you are exclusively task-oriented and don’t put your compassion into words, the patient thinks their pain, suffering and discomfort are “ho-hum” for you.</td>
</tr>
<tr>
<td>Socialize outside their room.</td>
<td>This creates the perception that you are goofing off, and when patients feel they need attention, this maddens them.</td>
</tr>
<tr>
<td>Wear strong colognes.</td>
<td>Many people who are sick find perfumes and colognes nauseating.</td>
</tr>
<tr>
<td>Wear jangly jewelry.</td>
<td>People who are sick are especially sensitive to clicks and clatters, squeaks and jangles.</td>
</tr>
<tr>
<td>Mosey in when responding to a call light.</td>
<td>For patients, every minute is an hour. When they push the button and you don’t display a sense of urgency, they doubt your caring.</td>
</tr>
<tr>
<td>“Dear, honey, sweetie.”</td>
<td>Some people don’t mind and caregivers certainly mean well, but many patients find it patronizing.</td>
</tr>
<tr>
<td>“Hold your horses.” “You’re not my only patient.”</td>
<td>Patients and families feel dismissed and discounted when they hear these words.</td>
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Engage teams in identifying the hot button behaviors and words in their roles with their customers. And make a pact to stop these from occurring.
Point 2: Coach staff to express caring out loud—using words that reflect empathy.

Help your team communicate their caring and receive the gratitude and trust of patients and families. Help people speak the language of caring.

<table>
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<tr>
<th>Language that Shows Caring</th>
<th>Examples</th>
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</table>
| Help staff acknowledge patients’ feelings. | “This must be so hard for you.”   
|  | “I’m so sorry about your pain.”   
|  | “You seem discouraged.”   
|  | “You seem tired.”   
|  | “I can imagine this might feel scary.”   |
| Help staff use the words “for you” over and over. It forces staff to realize that what they’re doing is for the patient. | “Let me open that for you.”   
|  | “Let me close this curtain for you.”   
|  | “Let me find your nurse for you.”   
|  | “Let me find a more comfortable wheelchair for you.”   
|  | “How about if I call your daughter for you?”   |
| Help staff regularly state their positive intent. | “I want to make you comfortable.”   
|  | “I want to keep you safe.”   
|  | “I want to help you relax.”   
|  | “I want to protect your privacy.”   
|  | “I really want to help you.”   |
| Help staff express positive regard for patients and families, even for those who appear difficult. | “I admire your courage.”   
|  | “I appreciate your patience.”   
|  | “I really appreciate your devotion to your mom.”   
|  | “Thank you so much for speaking up. It gives me the chance to correct this.”   
|  | “I’m sorry it took so long. Thanks for understanding.”   |
| Help staff combine these language skills into powerful statements. | “I’m sorry you were frustrated. I’m here now, and I want to help!”   |

I’m working with one inspirational leadership team on a housewide strategy to strengthen the competency of communicating with empathy. We’re encouraged to find that people can indeed learn to use the language of empathy.
Point 3: Help staff stop taking demands, impatience, frustration and pain as defiance or personal insults.

Help staff alter their inner dialogue or “self-talk” so that they no longer take patient demands and impatience personally.

<table>
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<tr>
<th>If You Think This:</th>
<th>Think This Instead:</th>
</tr>
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<tbody>
<tr>
<td>“Here she goes again! Now what!?”</td>
<td>“Let’s see if I can build her trust, so she can relax.”</td>
</tr>
<tr>
<td></td>
<td>“I have a chance to make a difference right now.”</td>
</tr>
<tr>
<td>“I didn’t deserve that outburst. Doesn’t she know that I care?”</td>
<td>“She’s sick and very upset. This outburst isn’t about me.”</td>
</tr>
</tbody>
</table>

Point 4: Institute regular processes that prevent desperation.

Quick connecting and comfort rounds are two examples.

**Quick connecting.** When my sister was in a coma, I found it upsetting that people referred to her as “she” or “her.” I decided to help caregivers see the person within. I covered the wall with family pictures and a big list of my sister’s special gifts and enthusiasms. When caregivers entered the room, they couldn’t help but read it; from then on, they called my sister Linda.

Why can’t a nurse who is meeting a new patient devote three to five minutes to asking the patient and/or family a standard set of questions that help to find out about this person and their story? And why can’t the nurse, with patient permission, post a few choice highlights on a white board so that co-workers also see this patient as a unique individual with a history, a life, passions and hopes for the future.

This three- to five-minute quick connecting process transforms the care relationship into a caring one. Caregivers see the patient as a person, not as “the heart,” “the hip” or a stick figure in the bed.
**Comfort rounds.** We know a patient will have to pee. We know they will get thirsty. They don’t plan ahead for these things. Once they call for help, it’s already urgent. Why wait until they call?

Comfort rounds are regular hourly rounds in which one staff member per unit (patient care associates, nursing assistants and nurses all take turns) makes rounds and checks on the comfort of every patient, not just his or her own patients.

“Hi, Mrs. James. I’m in the neighborhood. Can I help you to the john?” Proactive, hourly comfort rounds reduce accidents, falls, messes and cleanups, not to mention extreme patient frustration and indignity. Patients become less demanding and more trusting. They know they don’t need to beg for attention to their most basic needs.

Then, to also prevent desperation and show caring, how about getting more insistent on the use of this simple script: “I want you to feel comfortable and secure. Before I go, is there anything else I can do for you?”

**Point 5: Build staff communication skills by focusing on the difficult situations that deplete their energy.**

Sometimes health care professionals resist skill-building on communication. “I already do this.” “This is too basic.” “This is insulting.”

The good thing about difficult-for-me people and difficult situations is that people want to handle them better to reduce the stress caused by them. This presents a burning platform for training that meets with minimal if any resistance. Hold clinics on the difficult-for-me patient and nurture the trust-building and communication skills that drastically reduce the energy drain of difficult-for-me patients.
The Punch Line

While most patients are not inherently difficult, many do act in ways that try the patience and compassion of health care professionals. The result: a downward spiral toward both patient and staff dissatisfaction.

We can change this unfortunate dynamic. We are not powerless. More often than not, by instituting process improvements that prevent patient distress and anxiety and by overtly communicating empathy and caring, our teams can win patient trust and cooperation. It’s time to invest in developing our teams to achieve a new level of communication effectiveness that supports their caring work.
The Maddeningly Difficult Patient

WENDY LEEBOV—HeartBeat, November 2009, Volume 1, Issue 11

The Maddeningly Difficult Patient presents a maddeningly difficult challenge—almost daily.

Oops. I said “difficult patient” and I vowed never to use that term. I think it’s much more constructive to talk about “difficult situations” and the “difficult-for-me patient”. The fact is, because patients and families are so anxious during healthcare experiences and so out of their element, many people do not behave at their best. They are not inherently difficult. The situation is difficult for them.

Yet, since challenging patients and families produce so much stress for service providers, I am constantly trying to learn about ways to help. Recently, at a large medical organization, I ran a focus group with nurses, billing reps, registrars, phlebotomists and others KNOWN for dealing with difficult situations really well. I used behavioral interview questions to spark sharing and insights:
“Tell me in detail about a time you were challenged.”

- What were the circumstances?
- What happened exactly?
- What did they say?
- What did you say?
- What were you thinking?
- What did you do?
- How did the other person react?
- Then what did you do?
- And what were the results?

The energy for sharing these success stories was electric. (Note: You can use these same questions in a staff meeting to engage people in sharing successes and success strategies!) After people shared their stories, we developed a long list of pointers for others on handling difficult situations. Here are a select few:

**Four Pointers from Staff About Handling Difficult Situations**

1. It’s impossible to handle a situation well if you think of it as a battle. Your goal needs to be win-win for both parties.

2. It takes a generous heart to handle challenging people. Deep-breathe and remind yourself, “This isn’t about me,” and show all the more empathy and compassion, because the other person is, after all, stressed or agitated.

3. You need to know what your options are and feel clear in your own head about what’s negotiable and what isn’t. In many challenging situations,
you do everything possible to accommodate the other person and they still aren’t satisfied. In those cases, don’t get into arguments. Instead, hold firm (and here’s the hard part)—in a caring way—without becoming curt, impatient, rigid, or angry.

4. We all get “triggered” sometimes. If you are losing your composure, don’t be too proud to say that you want to consult another person (e.g. your supervisor or a colleague) who might be better able to address the customer’s issue.

My Favorite Skill: “Say It Again with HEART”

Getting more concrete, my favorite skill for these situations is “Say it again with HEART”. This skill has gotten me out of many jams—without damaging my relationship with the other person. (Try it with your kids!)

What is “Say it again with HEART”? Perhaps the customer complains, resists, accuses, or doesn’t want to take no for an answer? If you’ve done all you can responsibly do to accommodate the person and the person still isn’t satisfied or cooperative:

- Repeat your bottom line message—with lots of heart. Your bottom line message packed with expressions of caring becomes your closure statement.

- In response to your customer’s resistance or persistence, keep repeating this bottom line message—in a calm way. Don’t address each argument or excuse. Just hold your ground by kindly repeating yourself.
The Benefits

- You can say hard things and hold your ground in a caring way.
- The person on the receiving end hears your message clearly.
- You can remain calm and non-defensive with no regrets later about losing your composure.
- You can avoid argument and time-consuming debate.
- You can end the interaction without damaging your relationship.

The challenging patient (or family member or coworker) is only challenging if we feel challenged.

The prescription: Be forthcoming with caring and compassion even when the answer might be “no”.
Commanding Respect from Disrespectful Physicians

WENDY LEEBOV—HeartBeat, January 2011, Volume 3, Issue 1

“I work days and try to have everything ready when the doctors come in (labs in charts, vitals done). But they are immediately demanding everything at once, not giving me a minute to collect my thoughts and focus on the patient in question. Then, they treat me like I’m stupid when I don’t give the answers almost before they ask the question!”

Alan Rosenstein did a revealing study about nurse-physician relationships (http://www.nursingcenter.com/inc/journalarticle?Article_ID=278949) A few findings that struck me:

- More than 92% of nurses had witnessed disrespectful and/or disruptive behavior by physicians. The most common behaviors cited include yelling, raising the voice, condescension, berating colleagues, berating patients, and use of abusive language.

- Common generalizations about abusive behavior on the part of physicians make it seem as if most physicians are “abusive”.
However, in Rosenstein’s study, nurses clarify that very few physicians are abusive. The vast majority are not. I think that’s VERY important to remember.

Still, the instances of abuse stick in the craw of not only the people on the receiving end, but also on people who witness it. So, it’s important to address this behavior, so that it doesn’t erode morale, teamwork and patient outcomes. Of course, that’s not so easy, because many caregivers feel intimidated about speaking up to stop respectful or abusive behavior because of fear of retaliation, lack of assertiveness, and/or a sense of hopelessness that the person’s behavior will ever change.

What to Do?

There’s a lot the organization can do—and it should, such as:

- **Commit to and make explicit a code of conduct and link it to your vision, values and standards.** Highlight the impact of teamwork, collaboration and communication on quality, patient satisfaction, risk reduction, safety, and outcomes.

- **Zero tolerance:** Institute and enforce a zero tolerance policy about coworker disrespect.

- **Adopt a “respect” signal.** Decide on something anyone can say when they witness inappropriate behavior—a signal that means “You have crossed the line”. Stopped in their tracks, many people become more aware of their behavior and more accountable for it. My favorite signals:
  - “Time out.”
  - “How about a cup of coffee?”

- **Physician-nurse rounding:** Have physicians and nurses round on patients together and provide training to support effective communication during these rounds.
• Provide personal coaches for individuals who behave in an outrageous way.

• Adopt-a-Doc: Have nurses each adopt a physician with whom they will deliberately build a positive relationship and for whom they will act as an advocate.

• Provide assertiveness training for nurses! This is critical!

• Discussion forums: Provide forums in which physicians and nurses talk to each other!

...and more

BUT—while the organization can work to reduce abusive or disrespectful behavior between nurses and physicians and among colleagues in general, in my view, it is essential that the individual who perceives the behavior takes responsibility to address and handle it effectively one situation and one person at a time.

What Can the Individual Do?

In one of my roles years ago, I was in a position to field physician frustrations every day. My friends called me the LIVER of the organization, because so many toxins flowed through me. In my early years, in the face of a hostile physician, I would get defensive or cower. Both approaches seemed to increase the behavior I was hoping to eliminate. Then, after spending about $5 million on therapy, I learned other MUCH more effective techniques, and I have had a less stressful life ever since, because these techniques WORK.
Tips from my experience:

- **Alter your own inner monologue**—the statements you say to yourself. Look within: What do you say to yourself when someone is abusive to you? “This jerk! How awful! Poor me! I hate this! I don’t deserve this!” If your inner talk makes you angrier or more defensive, change it. You CAN decide to think something different, such as, “This is not about me.” “I deserve respect.” “I don’t have to react.” “I can stay calm and help this person.” “I can take the high road here.”

- **Don’t respond in kind.** It’s human nature to want to strike back when attacked. Resist. Handle the inappropriate behavior respectfully. Stay on the high road, since this will make you most effective and also enable you to feel good about yourself at the end of the day. CALMLY SAY, “What is happening is not okay.”

- **Give direct feedback without anger.** “I saw you do this....” Or, “I don’t appreciate your tone.” “I would appreciate your keeping your voice down.” “When you belittle me in front of our patients, I resent it and it makes it hard for me to support you.”

- **When someone is verbally attacking, instead of getting defensive, make explicit your positive intent.** Instead of saying, “WHOA! Hold it a minute!”, say “You know, I really want to help you.” Then, if they persist, say that over and over in a sincere tone, “As I said, I really DO want to help you.” And then wait until they have vented enough to allow them to calm down and address the facts of the situation with you.

- **Use the caring broken record.** In the face of persistent disrespect, repeat your bottom line message—each time with caring. “I hear how frustrated you are, and I really want to support you.” “I realize you’re under extreme pressure, and I really do want to provide the support you need.” “I’m sorry this isn’t what you wanted. I really do want to help.”
If the abuse continues, remove yourself from the situation. “I’m hanging up now. Please call me back when you’re ready to talk with me in a respectful way about this. I really do want to help you.”

“There you go again.” If you’ve addressed the behavior over and over and it still hasn’t changed, when it happens next, say very calmly, “There you go again. I want to discuss this with you when we can both be respectful.” And do that EVERY time it happens again.

And with Your Team?

Talk about the elephant in the room: Work together with your team to identify great ways to respond to the disrespectful or inappropriate behavior you handle most often. I’ve provided a worksheet to guide your discussions. You can be sure you’re not alone. So, the activity will help everybody.

A Few Examples

<table>
<thead>
<tr>
<th>Situations Most Likely to Trigger Abusive Behavior</th>
<th>Responding with Backbone and Heart</th>
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</thead>
<tbody>
<tr>
<td>Placing calls to physician</td>
<td>“Thank you for taking my call. I want to clarify the plan for our patient.”</td>
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<tr>
<td>Ill-timed calls to physician</td>
<td>“I’m sorry if I’m disturbing you at home. I want to be sure I do the right thing for our patient.”</td>
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<tr>
<td>Questioning or seeking to clarify physician’s orders</td>
<td>“I know how much you care about your patients. I’m concerned that…” “For the sake of the patient, let me be sure I’m clear about what you want.” “I have a concern about the med you ordered and I want to be sure to do the right thing for your patient.”</td>
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<tr>
<td>When physician thought their orders were not being carried out correctly or in a timely manner</td>
<td>“I realize you’re frustrated. Can we talk a minute to clarify what needs to happen now?”</td>
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</tbody>
</table>
Healthcare environments are inherently stressful and it’s upsetting to think about the times when colleagues add to this stress instead of relieving it. To be effective and to do your part in altering an atmosphere of disrespect, it takes courage and caring—backbone and heart.

**Let’s help each othernip disrespectful behavior in the bud.**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Suggested Comeback with Backbone, Respect and Caring</th>
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Helpful resources for handling disrespectful behavior


Language of Caring for Staff® is a skill-building program that offers staff the communication competencies for expressing their caring and empathy.

The Results: An energized, gratified workforce, an exceptional and healing patient experience, improved safety, higher CAHPS scores, less anxious and more engaged patients.

Typical Implementation Process

1. Assessment and planning
2. Communication skill-building
3. Leadership support and development
4. Sustaining improvement

Communication Skill-Building: Ten Modules with Videos

Developed by Wendy Lebov, Ed.D., best-selling author and patient experience thought leader

1. Introducing The Language of Caring
2. Heart-Head-Heart™ Communication
3. The Practice of Presence
4. Acknowledging Feelings
5. Showing Caring Nonverbally
6. Explaining Positive Intent
7. The Blameless Apology
8. The Gift of Appreciation
9. Say It Again with HEART
10. The Language of Caring: From Good to GREAT

Features

- Managers/champions lead!
- One skill at a time
- Short team sessions – under 30 minutes
- Compelling videos shot on location at Banner Health
- Built-in feedback and habit-building
- CEU-ready
- Web access to all resources on the Language of Caring Client Portal

www.languageofcaring.com
Language of Caring for Staff®

- Creates alignment by developing a common language and skill set for caring communication
- Mobilizes employees as engaged contributors who together create a community of caring
- Makes your initiatives, like rounding, pain management and reducing readmissions, more effective
- Encourages empathic communication, engagement and partnership—the keys to patient and family-centered care
- Leads to improved safety, better outcomes and higher CAHPS scores

Among Language of Caring Clients

Hospitals, Health Systems & Medical Groups

- Johns Hopkins Medicine, MD
- MD Anderson Cancer Center, TX
- Children’s Hospital of Philadelphia, PA
- American Red Cross, DC
- Harvard University Health Services, MA
- Memorial Hermann Health System, TX
- Lourdes Hospital, NY
- Children’s Hospital of Wisconsin, WI
- MedStar Washington Hospital Center, DC
- Wentworth Douglass Hospital, NH
- Wentworth Health Partners, NH
- Terros Health, AZ
- United Health Group, WI, NC
- CHI Franciscan Medical Group, WA

Spoken from the Heart

“I see and hear stories about Language of Caring every day. Employees come to me and say, ‘I used Language of Caring with a difficult family today and it really worked’. That’s very rewarding.”

Amy Lambert, Senior VP
Children’s Hospital of Philadelphia Care Network

“The friendliness and atmosphere started to change once we started Language of Caring. It’s reminding us why we’re here.”

Lucky Romero, Inventory Associate
Banner Health System

Connect with us!

Jill Golde | Partner & SVP, Market Development
314-571-9607
golde@languageofcaring.com

Cheryl Glass | VP, Business Development
314-256-1415
glass@languageofcaring.com

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