Satisfaction: Toward Better Care for Patient and Clinician

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Keeping your patients satisfied can help keep you sane—and possibly even happy. Here: strategies for enhancing clinician/patient communications.

According to Dr Robert Strauss from the University of Cincinnati, keeping your patients satisfied can help keep you sane—and possibly even happy.

Dr Strauss covered this and related topics during his lecture at the American College of Emergency Medicine 13th annual symposium in Seattle (ACEP13) entitled “Satisfied Physicians Have Satisfied Patients: Improving the Physician Experience by Improving the Patient Experience.”

Dr Strauss referred to studies on communication showing that verbal content alone was a small part of the information exchanged between people during a face-to-face conversation. Tone and visual cues were equally—if not more important—to overall communication, and the percentage values of their relative importance may be surprising to many. Verbal content, tone and inflection, and visual communication with body language and facial expressions accounted for 7%, 38%, and 55%, respectively, of the importance of overall interpersonal communication. Taken another way, verbal content can become lost in body language and vocal expressions, both of which the clinician may not be completely aware of, but which are nevertheless perceived by the patient on multiple levels.

**Body language.** Incongruence between verbal content and non-verbal cues during communication can lead to mistrust and/or ineffective communication between the patient and the clinician. This can occur in both directions. It would therefore be useful and desirable for clinicians to become more aware of the non-verbal cues they are producing as well as to do their best to accurately “read” non-verbal cues from their patients.

Non-verbal cues likely become more important during difficult situations, such as with an unsatisfied or demanding patient, or when the clinician is behind schedule or overworked.

**What clinicians say, and what patients hear.** Another challenge according to Dr Strauss: studies show that little of what the provider wants to communicate to the patient is actually received and remembered. We may actually say a lot less than what we mean to say or think we said and patients often only recall a fraction of what we actually tell them. Because of time constraints, health care providers often use verbal shortcuts, which may lead to misunderstanding—especially when our tone of voice is not what we think it is or would hope it to be. Factors that can lead us inadvertently to use an unsympathetic tone include time pressure or a difficult or demanding patient. Therefore, it is especially important to try to pay attention to your tone in these situations. By keeping tabs on our internal emotion, we can to improve our tone of voice or facial expression when it goes off track.

But by doing so, we clinicians do more than just improve our communication and collaboration with patients. It may also improve our own attitude at work. As we internalize improvements in tone and expression, we may find ourselves happier at work. These same concepts can and should also be applied to communications with our colleagues at work, including EMTs, medical assistants, nurses, secretaries, housekeeping, etc.

**Dealing with a difficult patient.** Unfortunately, despite our best efforts and attempts to be aware of our non-verbal communication, sometimes we just can’t win. When you are engaged in a particularly difficult communication situation (AKA an impossible patient), trying to get him or her to see things your way may backfire. Knowing when to give up can minimize time wasted. Dr Strauss advised: “Choose your battles . . . never wrestle with a pig. They enjoy it and you just get dirty.”

Remember, you are working your tail off, but at least generating income. Your patient is waiting,
wasting time, and may be in pain. It is no coincidence that the term “patient” and “patience” look so similar. They both originate from the Latin word meaning “to suffer.”

**Making waiting a little easier.** The least we can do is to try to alleviate some of that suffering. Studies have shown that the psychology of waiting is such that it is more difficult if one is in pain or does not know how long to expect to wait. Waiting can be made easier by providing analgesia, distractions such as TV or magazines, and/or realistic expectations of how long the wait will be.

**Managing patient expectations.** Staff should avoid using phrases such as, “I’ll be right back” or “The doctor/nurse will be here in a few minutes.” Dr Strauss recommends giving wait time estimates that are 2 to 3 times longer than you think things will actually take. Patients generally become frustrated when things take longer than you estimate, but are often pleased when things take less time, even if the actual wait time is the same. *Under-promise and over-perform* is the mantra to live by with expectation management.

To improve non-verbal communication, maintain eye contact while you are seated at eye level with the patient. In this way, patients are more likely to perceive you as not in a rush and more caring, according to Dr Strauss. A soft, empathetic tone of voice is also very helpful to both patient and provider satisfaction. If you appear and sound more empathetic, you not only put patients at ease . . . you actually internalize this appearance and feel and become more empathetic.

**Scripting.** Another tool Dr Strauss recommends is scripting. Having key phrases you use for specific recurrent situations at work—whether you invent them or borrow them from a colleague—can lead to more smooth and effective communication. Scripting can be very useful for difficult or even routine communication. One Dr Strauss likes to use to make a 2- or 3-hour wait for a CT scan seem short is, “If you get a CT scan from your provider’s office, it might take a week to get it ordered, done, and obtain the results. If we do it here it will only take about 3 or 4 hours.”

Other examples he uses to improve his Press-Ganey scores are: “I’m closing the curtain because I care about your privacy,” and “It’s important to me that you are kept informed. Do you have any questions?”

Matching negative emotions with a difficult patient often backfires. One script Dr Strauss recommends with an angry patient is, “Yes, it’s frustrating to wait when you’re not feeling well, but I’m here now to take care of you.” The theory of “Yes” is a type of scripting in which you start an answer to a request with the word “yes,” even when the real answer may end up being “no.” Dr Strauss acknowledged that although scripting can feel awkward at first, once it is incorporated into your daily routine, it becomes more natural.

Give it a try.

In summary, if we work on our non-verbal communication skills—like body posture, eye contact, and tone of voice—and we learn to overestimate wait times and use scripting in key situations, and if we do this not only with our nice patients, but also our difficult patients and our colleagues and staff as well, then the people we treat and the people we work for will likely be a little happier. All this, in turn, will help make us happier and mold us into better clinicians and better people, not just at work, but at home as well.

Good luck!

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