Communication: The Patient & Provider Experience

MPPDA ~ Las Vegas, April 21st, 2016

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MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Agenda

- Patient experience is a measure of quality
- Role of empathy
- Risk of burnout
- Reducing suffering

"…for the secret of the care of the patient is in caring for the patient."

-Francis W. Peabody, MD
October 21, 1926.

What do patients want?

- To be valued
- To be listened to
- To be cared for
- To be cared about
- To be treated as an individual

What do patients see?

Toll, E. The cost of technology. JAMA 2012; 307(23): 2497-2498

What do patients need?

Reducing the Trauma of Hospitalization

A.S. Detsky & H. Krumholz, JAMA, May 1, 2014

VIEWPOINT

Reducing the Trauma of Hospitalization

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US health policy analysts and payers are currently focused on the high rate of hospital readmission for patients who have been recently discharged. This issue is a particular concern for people older than 65 years and thus has become a focus of Medicare, which has implemented incentives to reduce 30-day readmission rates. Hospitals that fail to meet targets will be financially penalized.[1] Acting on common sense, rather than evidence and a firm understanding of the causes of readmission, many suggest that rates could be reduced if hospitals only increased efforts to improve transitional care. Work began with greater attention to the cause of hospitalization and also on improved communication at the time of discharge and shortly thereafter.

Although these actions are sensible, data have suggested that the issue is more complicated. Only a minority of patients treated for common conditions such as heart failure, chronic obstructive pulmonary disease, and pneumonia are readmitted for precisely the same problem.[2] It seems that patients who leave the hospital have their physiological balance disrupted and are subsequently susceptible to a broad range of acute medical problems.

The depersonalizing and stressful hospital atmosphere that exposes patients to incessant loud noises, a lack of privacy, awakenings in the middle of the night, and examinations by strangers who fail to identify themselves may be an important contributing cause of transient vulnerability that has been characterized as "post-hospital syndrome."[3] It may be meaningful that this term is similar to posttraumatic stress disorder, implying that [illegible] come truly healing environments? Are some principles so clear that action should be taken now rather than after years of study? This Viewpoint offers suggestions for consideration.

Promote personalization

Trauma-Reducing Innovations in Hospital Care

Promote Personalization

Hospitals and health care personnel should use techniques to ensure that patients are respected, such as helping each patient feel like an individual. When possible, processes should be eased; or applying [illegible] from pediatric hospitals with regard to allowing increased flexibility, providing comforts to accommodate family members, and having a cheerful decor. The patient perspective deserves attention; for example, consultants should make appointments so patients can plan around the meeting, perhaps facilitating attendance of family members. Also, patients should be encouraged to wear personal items of clothing. They do not need to be in positions where they can be readily exposed to examiners throughout the day. This would help patients maintain their self-esteem and orientation and would also remind their care professionals to recognize them as people.

Ensure rest

Ensure That Patients Receive Enough Rest and Nourishment

Hospitals should prioritize ensuring that patients have an environment conducive to sleep, with efforts to maintain their circadian rhythm and reduce needless nighttime disruptions and pervasive sounds of monitor alarms. They should also pay close attention to nutrition and prioritize creating opportunities to provide nutritionally appropriate, appetizing food served at the intended temperature. The imposition of a [illegible] bolic patient. Sleep deprivation and poor nutrition should be considered toxic to the patient—a harmful exposure to be avoided.

Reduce disruptions

Reduce Stress, Disruptions, and Surprises

Stress is also toxic and can emanate from uncertainty, unforeseen events, and anxiety. Patients should be given a schedule for the day. There should be tools to help them understand the roles of their health care professionals. Patients should know the name of and be able to recognize their physician of record (known in some hospitals as the most responsible physician). Clinicians and other care professionals should announce themselves before entering the patient's room and wear easy-to-read name badges with a description of their roles. Every person who enters the room should sign a logbook so patients and their families know exactly who has visited [illegible] can be created so names are recorded automatically (such as using chip technology in identification badges) when a member of the hospital staff enters and leaves the room. Doors to patient rooms should be closed to reduce noise and give privacy. Patients should not share rooms or bathroom facilities with other patients to prevent strangers from overhearing personal information and avoid transmission of [illegible] quires improved mechanisms of detecting when patients need assistance. The simple call-button technology [illegible] accountability for response times can be part of every institution.

Eliminate unnecessary tests and procedures

Eliminate Unnecessary Tests and Procedures

Blood draws should not be considered innocuous. There is no need to routinely order blood work daily for all hospitalized patients. Electronic health systems have developed order sets that frequently encourage excessive phlebotomy and these must be adjusted to permit easy cancellation of unnecessary tests. Even tests that

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seem innocuous like routine urine cultures in asymptomatic patients can cause problems if positive results lead to prescribing antibiotics inappropriately.

Encourage activity

Decrease Random Medication Alterations

The practice of on-call physicians making rushed judgments to alter or add medications in response to transient problems, such as elevated blood pressure or heart rate, should be modified. The physiological stress of starting new medications in this fashion exposes patients to undesirable drug interactions and adverse effects.

Encourage Activity

Deconditioning should also be considered toxic. Attention to physical activity and physical therapy for all conditions should begin as [illegible] a few days of bed rest for older individuals can threaten their independence.[5] All patients who are physically able should be encouraged [illegible] be provided.

Communicate discharge instructions clearly

Provide a Postdischarge Safety Net

Follow-up appointments should be made prior to patients leaving the hospital, with clear communication of who will see them, when and where the follow-up visit will happen, and the name of a specific person (and method for contacting) should problems arise. Patients should be clearly informed about who will take ownership over their care once they leave the hospital. The phrase "Someone will call you ..." should be replaced with " I will call you and here is how you can find me if you need me." Provision of this kind of information should be varied to accommodate transient cognitive dysfunction—the fog that may occur after the trauma of hospitalization—that may exist at the time of discharge.

Conclusions

This agenda will certainly take effort. Some hospitals, particularly in some major US metropolitan areas, have already implemented many of these suggestions by designing floors that deliver first-class amenities while charging patients additional fees, establishing the feasibility of doing so. Perhaps some of the money that hospitals are spending on delivering excessive technology could be diverted to make hospitalizations less traumatic for everyone, possibly improving outcomes at the same time. Information technology such as identification badge chips and scheduling programs to inform patients when consultants will see them may help. However, the principal innovation has to start by having those who run hospitals look at the experience from the patients' perspective rather than the perspective of those who are providing care. This transition may require expertise from other customer-oriented industries outside of health care. Re-engineering the process of hospital care will involve rethinking many of the traditional procedures and technologies such as obtaining daily blood work and nighttime vital signs, maintaining continuous intravenous access, and using vital sign and infusion alarm systems that continuously alert caregivers with irritating noises and beeps. Once those steps have been taken, hospitals can implement changes that may well have important benefits in helping patients recuperate from illness without requiring a prolonged period of recovery that stems from the way that care was delivered.

ARTICLE INFORMATION

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1. Chen C, Ackerly DC. Beyond ACOs and bundled payments: Medicare's shift toward accountability in fee-for-service. *JAMA*. 2014;311(7):673-674.

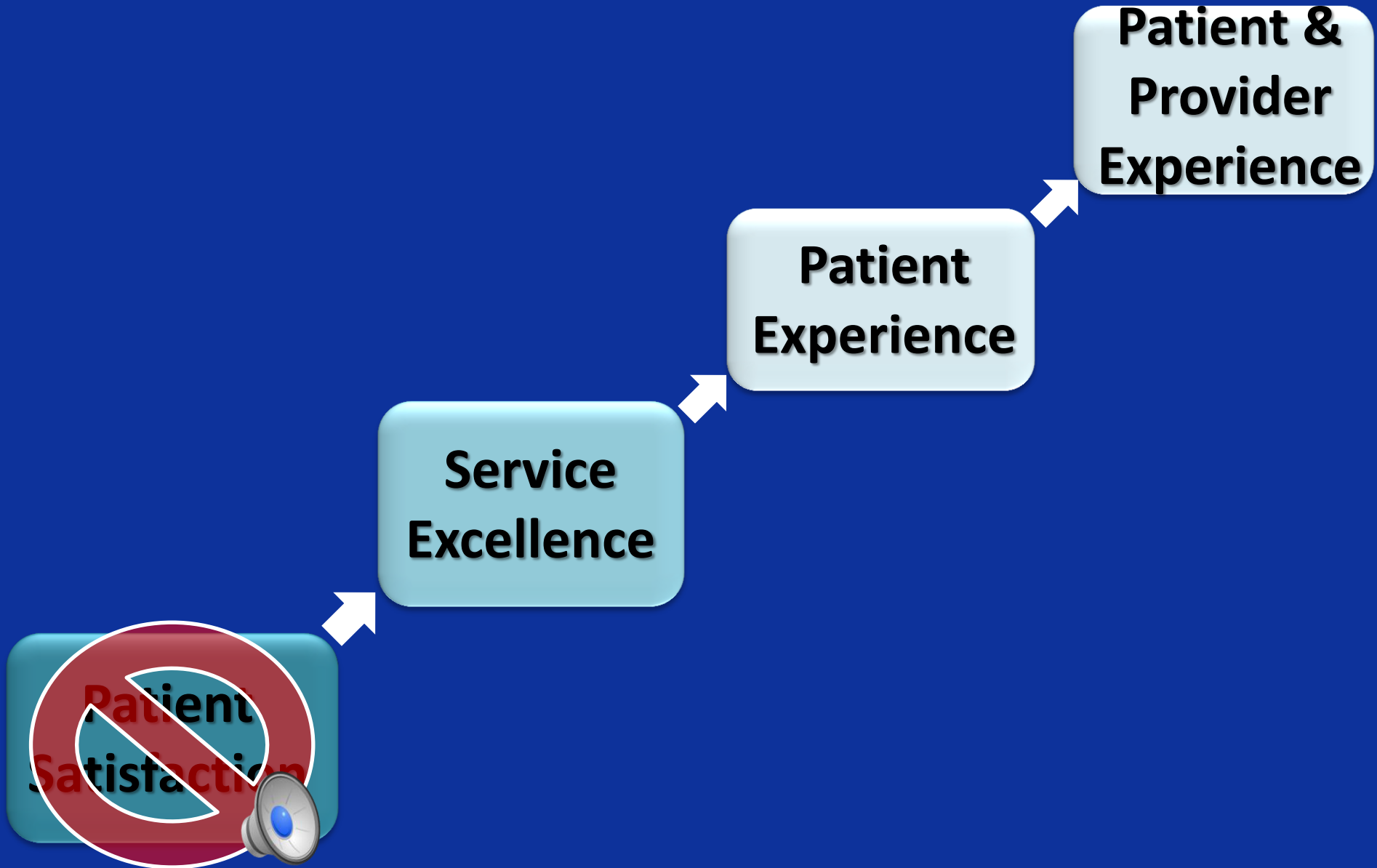
2. Dharmarajan K, Hsieh AF, Lin Z, et al. Diagnoses and timing of 30-day readmissions after hospitalization for heart failure, acute myocardial infarction, or pneumonia. *JAMA*. 2013;309(4):355-363.

3. Krumholz HM. Post-hospital syndrome—an acquired, transient condition of generalized risk. *N Engl J Med*. 2013;368(2):100-102.

4. Detsky ME, Etchells E. Single-patient rooms for safe patient-centered hospitals. *JAMA*. 2008;300(8):954-956.

5. Sinha SK, Detsky AS. Measure, promote, and reward mobility to prevent falls in older patients. *JAMA*. 2012;308(24):2573-2574.

Healthcare Experience Evolution



Healthcare Experience

- Do Not Harm Me
- Heal Me
- Be Kind to Me

HSR Health Services Research

DOI: 10.1111/j.1475-6773.2010.01122.x
RESEARCH ARTICLE

The extent to which patient experiences with hospital care are related to other measures of hospital quality and safety is unknown.

The Relationship between Patients' Perception of Care and Measures of Hospital Quality and Safety

Thomas Isaac, Alan M. Zaslavsky, Paul D. Cleary, and Bruce E. Landon

Background. The extent to which patient experiences with hospital care are related to other measures of hospital quality and safety is unknown.
Methods. We examined the relationship between Hospital Consumer Assessment of Healthcare Providers and Systems scores and technical measures of quality and safety using service-line specific data in 927 hospitals. We used data from the Hospital Quality Alliance to assess technical performance in medical and surgical processes of care and calculated Patient Safety Indicators to measure medical and surgical complication rates.
Results. The overall rating of the hospital and willingness to recommend the hospital had strong relationships with technical performance in all medical conditions and surgical care (correlation coefficients ranging from 0.15 to 0.63; $p<.05$ for all). Better patient experiences for each measure domain were associated with lower decubitus ulcer rates (correlations -0.17 to -0.35; $p<.05$ for all), and for at least some domains with each of the other assessed complications, such as infections due to medical care.
Conclusions. Patient experiences of care were related to measures of technical quality of care, supporting their validity as summary measures of hospital quality. Further study may elucidate implications of these relationships for improving hospital care.

Patient experiences of care were related to measures of technical quality of care, supporting their validity as summary measures of hospital quality.

Key Words. Patient assessment/satisfaction, quality of care/patient safety (measurement), hospitals

The quality of medical care provided by hospitals is often less than that of

organizations, has identified standard measures of hospital quality that can be

date, the HQA program has focused largely on process measures for three

Isaac, T., Zaslavsky, AM, Cleary, PD and Landon BE. The Relationship Between Patients' Perception of Care and Measures of Hospital Quality and Safety, 2010.

Physicians' Empathy and Clinical Outcomes

- Improved hemoglobin A1c scores
- Improved LDL-C test scores.
- Also increased medical compliance
- Less depression during cancer treatment
- Faster recovery from the common cold

Frequency and Percent Distributions of the Hemoglobin A1c and LDL-C Test Results for 891 Diabetic Patients, Treated Between July 2006 and June 2009, by Levels of Their Physicians' Empathy*

Patient outcome	No. (%) of patients by levels of physicians' empathy		
	High (n = 205)	Moderate (n = 282)	Low (n = 404)
Hemoglobin A1c†			
<7.0%	115 (56)	139 (49)	163 (40)
≥7.0% and ≤9.0%	59 (29)	99 (35)	135 (34)
>9.0%	31 (15)	44 (16)	106 (26)
LDL-C‡			
<100	121 (59)	149 (53)	180 (44)
≥100 and ≤130	56 (27)	86 (30)	128 (32)
>130	28 (14)	47 (17)	96 (24)

* From a study of physicians' empathy and patients' outcomes, Jefferson Medical College.
† $\chi^2_{(4)} = 22.04$, $P < .001$.
‡ $\chi^2_{(4)} = 15.55$, $P < .001$.

Hojat., M, et al. Physicians' Empathy and Clinical Outcomes for Diabetic Patients. Academic Medicine. 2011:86(3); 359-364.
Kim, S.S., Kaplowitz, S and Johnson, M.V. The effects of physician empathy on Patient Satisfaction and Compliance. *Evaluation and the Health Professions* 27 2004: 237-254.
Neumann, M., et al. Determinants and Patient – Reported Long-term Outcomes of Physician Empathy in Oncology: A structural equation modeling approach. *Patient Education and Counseling 69*. 2007: 63-75.

The Patient Experience and Health Outcomes

…patient-experience surveys provide robust measures of quality, and our **efforts to assess patient experiences should be redoubled.**

…increased patient engagement leads to lower resource use and greater patient satisfaction.

…patient-reported measures are not only strongly correlated with better outcomes but also largely capture patient evaluations of care, focused on communication with nurses and physicians.

Manary, MP, Boulding, W, Staelin, R and Glickman, S.W. New England Journal of Medicine. January 17, 2013. 368(30): 201-203.

The Patient Experience is a Measure of Quality

- Measured by our patients
- Measured by the GMEC
- Measured by the Federal Government

Patient Experience Surveys

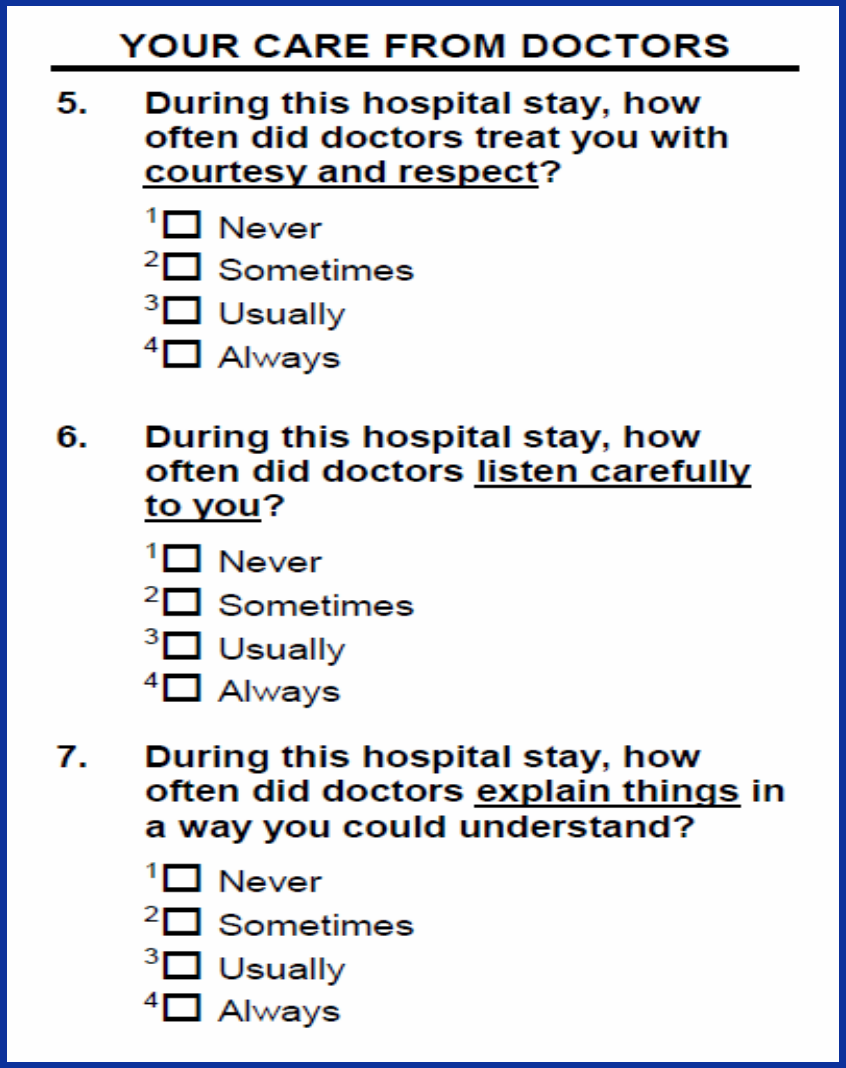
HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems

- In 2007, the Joint Commission called to improve communication across the continuum of care
  - Developed with CMS
  - Endorsed by National Quality Forum
  - Approved by Federal Office of Management & Budget
- 3 Main goals for HCAHPS
  - Produce comparable data
  - Enhance accountability and create transparency
  - Create incentives for hospitals

HCAHPS Questions

- 27 questions rating perception of care on a Likert scale
- Questions are divided into functional groups, including Your Care from Doctors



YOUR CARE FROM DOCTORS

5. **During this hospital stay, how often did doctors treat you with courtesy and respect?**

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

6. **During this hospital stay, how often did doctors listen carefully to you?**

[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

7. **During this hospital stay, how often did doctors explain things in a way you could understand?**

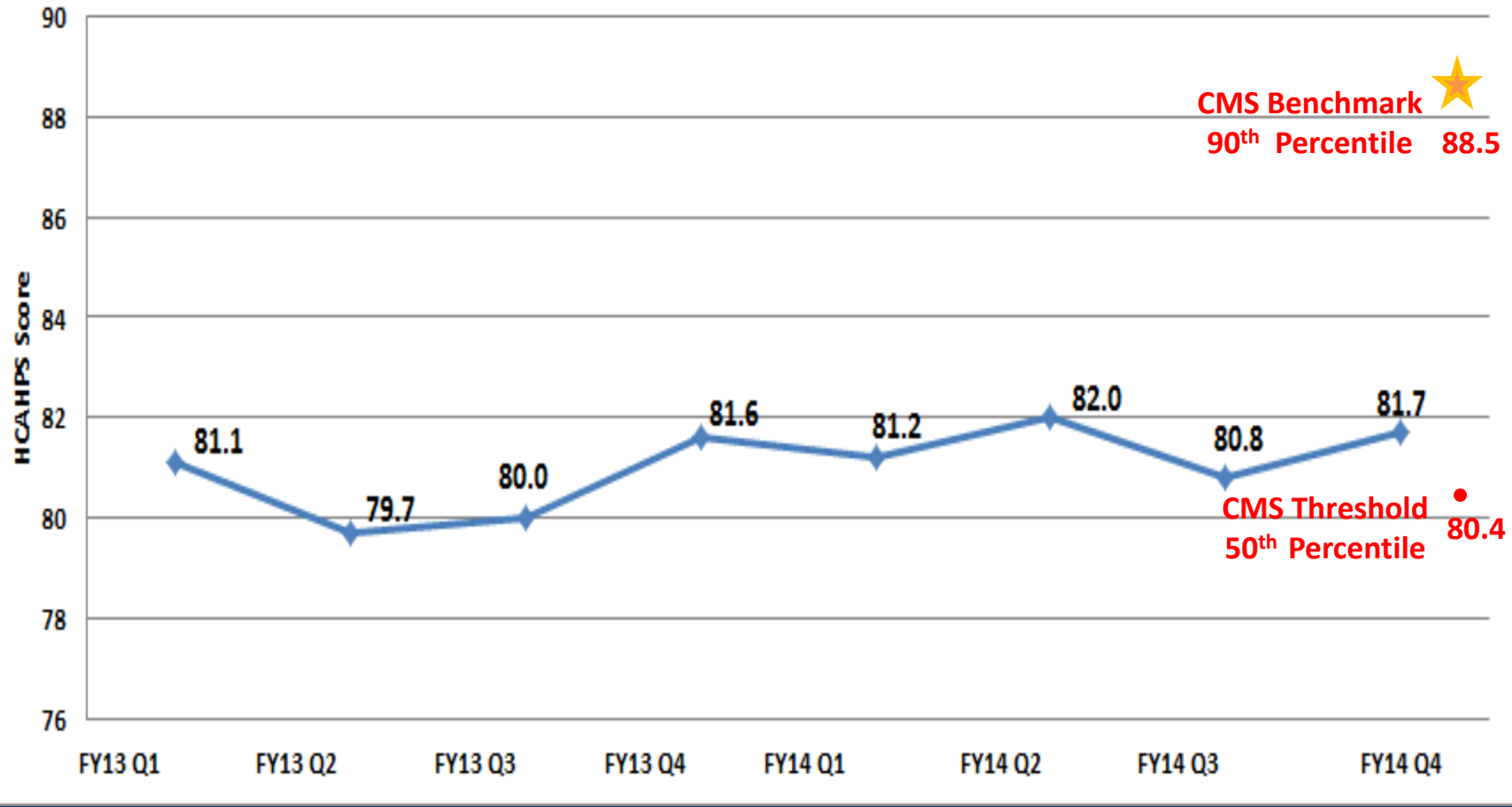
[1] ☐ Never
[2] ☐ Sometimes
[3] ☐ Usually
[4] ☐ Always

Reality Check…

How are we doing?

Yale-New Haven Hospital

HCAHPS Physician Communication Domain Scores
10/01/2012-9/30/2014

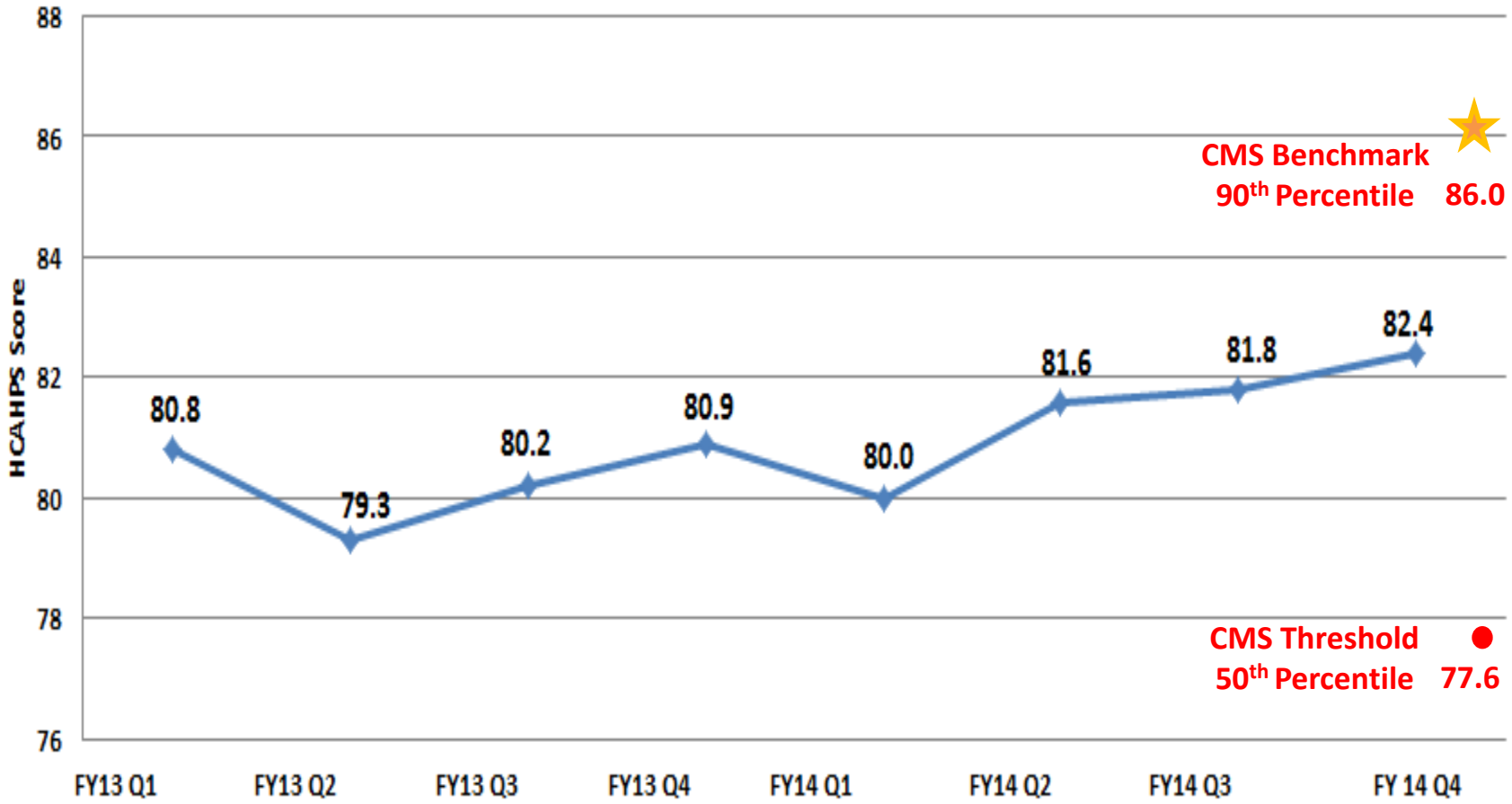


Data displayed by discharge date as of 12/04/14

Yale-New Haven Hospital

HCAHPS Nurse Communication Domain Scores

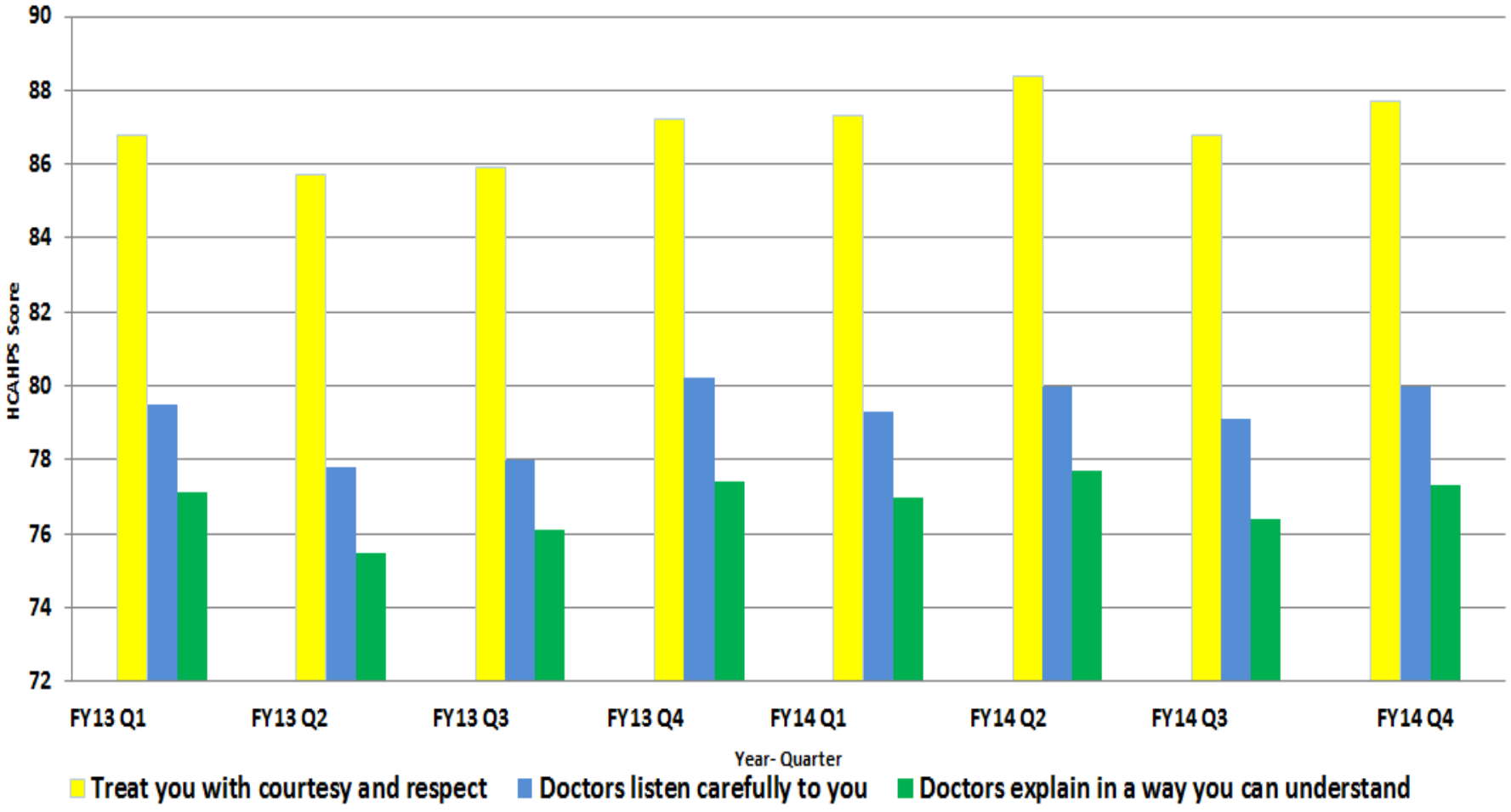
10/01/2012-9/30/2014



Data displayed by discharge date as of 12/04/14

YALE-NEW HAVEN HOSPITAL

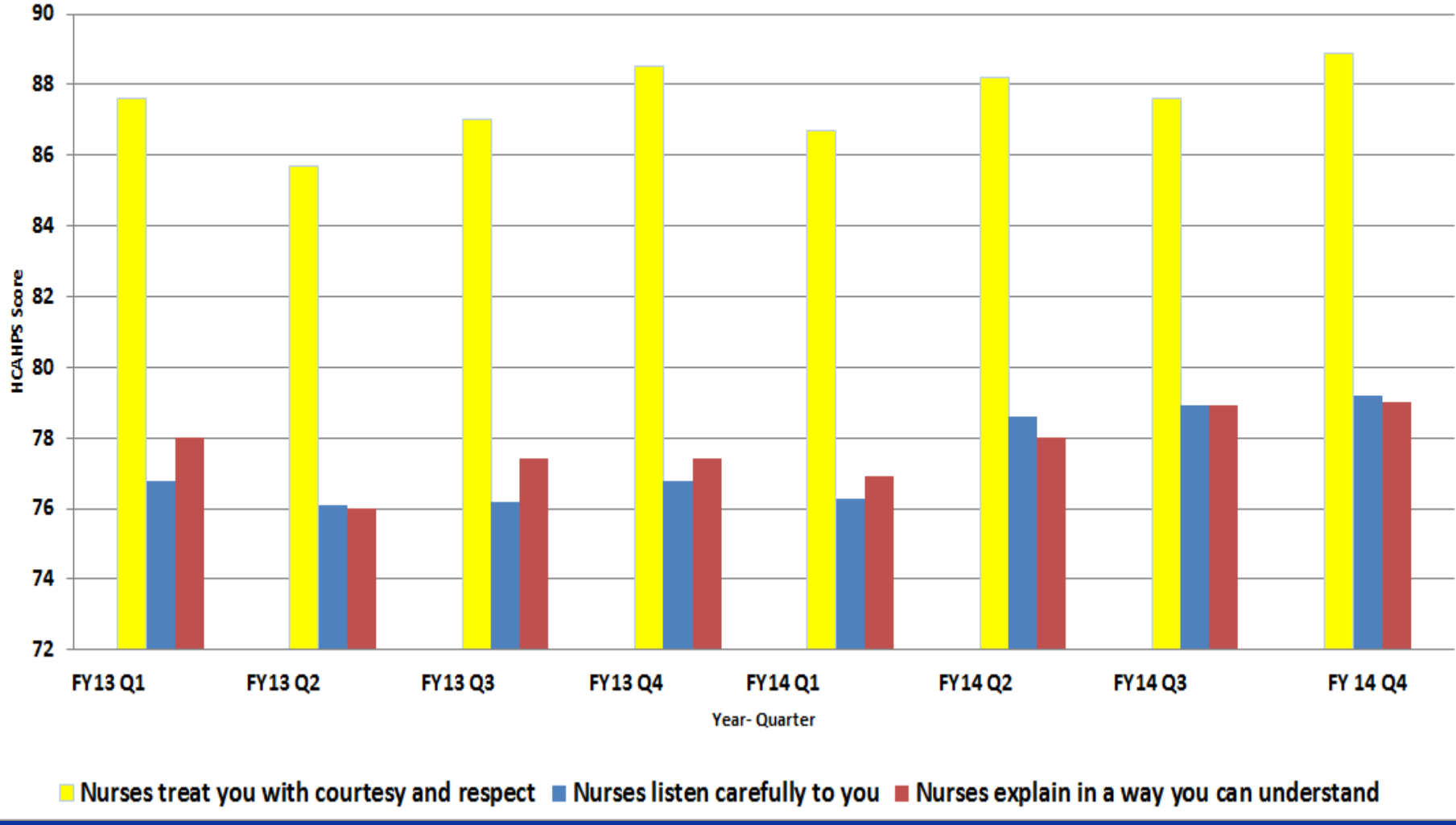
HCAHPS Physician Communication Scores by Question
10/01/2012-9/30/2014



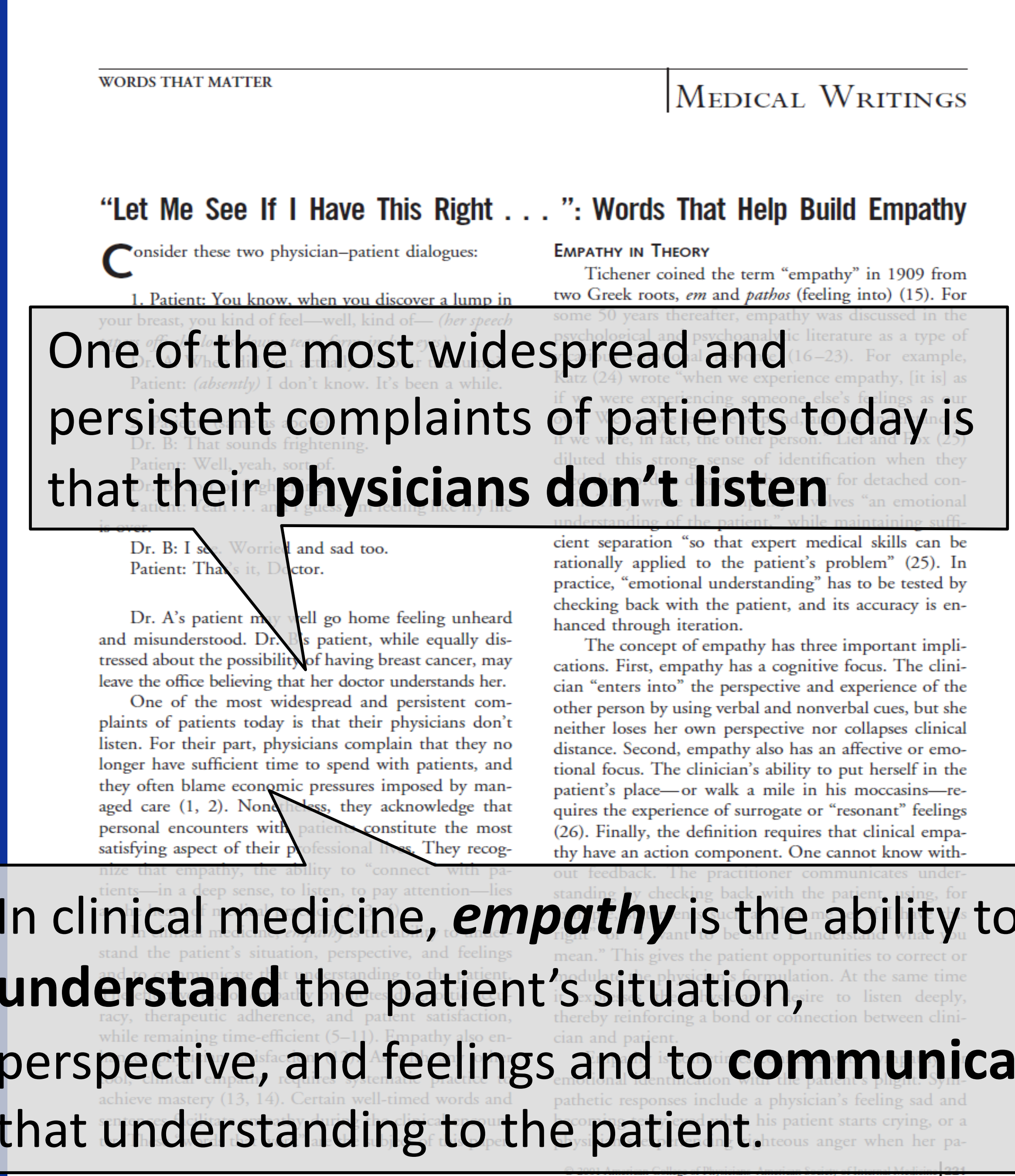
Data displayed by discharge date as of 12/04/14

Yale-New Haven Hospital

HCAHPS Nurse Communication Scores by Question
10/01/2012-9/30/2014



Data displayed by discharge date as of 12/04/14



WORDS THAT MATTER

MEDICAL WRITINGS

"Let Me See If I Have This Right . . . ": Words That Help Build Empathy

Consider these two physician–patient dialogues:

1. Patient: You know, when you discover a lump in your breast, you kind of feel—well, kind of— *(her speech*

Patient: *(absently)* I don't know. It's been a while.

Dr. B: That sounds frightening.

Patient: Well, yeah, sort of.

Dr. B: I see. Worried and sad too.

Patient: That's it, Doctor.

Dr. A's patient may well go home feeling unheard and misunderstood. Dr. B's patient, while equally distressed about the possibility of having breast cancer, may leave the office believing that her doctor understands her.

One of the most widespread and persistent complaints of patients today is that their physicians don't listen. For their part, physicians complain that they no longer have sufficient time to spend with patients, and they often blame economic pressures imposed by managed care (1, 2). Nonetheless, they acknowledge that personal encounters with patients constitute the most satisfying aspect of their professional lives. They recognize that empathy, the ability to "connect" with patients—in a deep sense, to listen, to pay attention—lies

EMPATHY IN THEORY

Tichener coined the term "empathy" in 1909 from two Greek roots, *em* and *pathos* (feeling into) (15). For some 50 years thereafter, empathy was discussed in the psychological and psychoanalytic literature as a type of

cient separation "so that expert medical skills can be rationally applied to the patient's problem" (25). In practice, "emotional understanding" has to be tested by checking back with the patient, and its accuracy is enhanced through iteration.

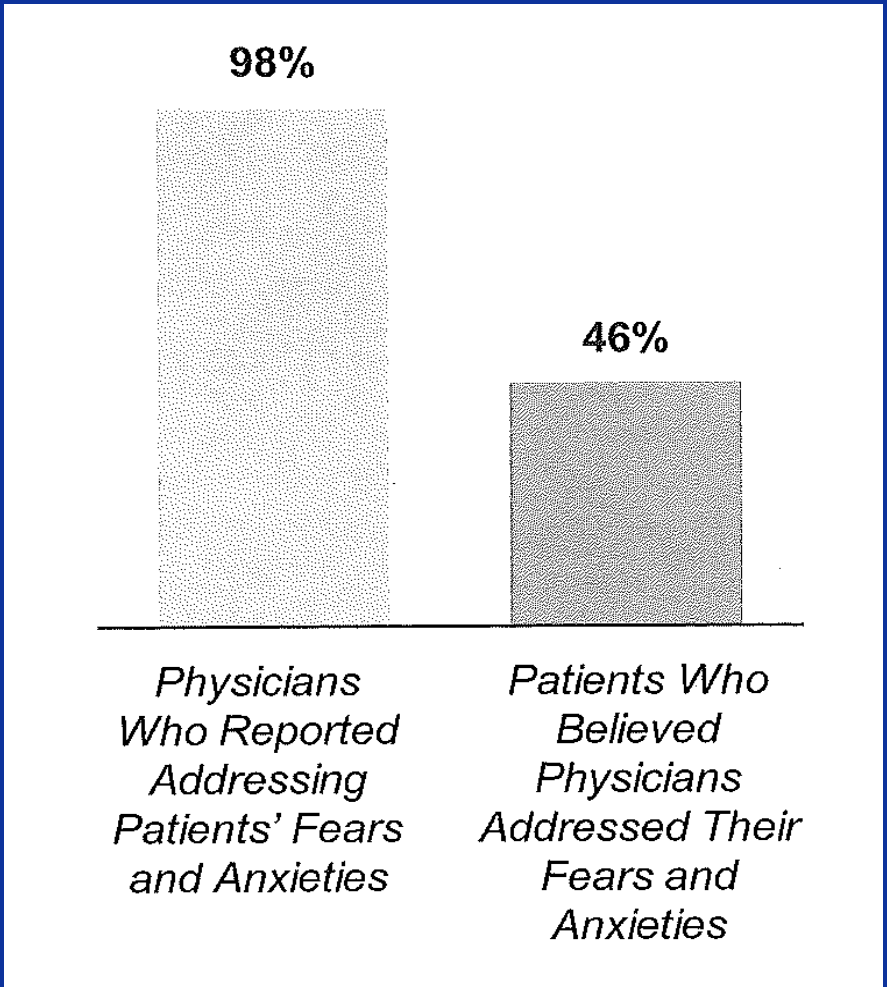
The concept of empathy has three important implications. First, empathy has a cognitive focus. The clinician "enters into" the perspective and experience of the other person by using verbal and nonverbal cues, but she neither loses her own perspective nor collapses clinical distance. Second, empathy also has an affective or emotional focus. The clinician's ability to put herself in the patient's place—or walk a mile in his moccasins—requires the experience of surrogate or "resonant" feelings (26). Finally, the definition requires that clinical empathy have an action component. One cannot know without feedback.

One of the most widespread and persistent complaints of patients today is that their **physicians don't listen**

In clinical medicine, ***empathy*** is the ability to **understand** the patient's situation, perspective, and feelings and to **communicate** that understanding to the patient.

"Let Me See If I Have This Right…": Words that help build empathy. Annals of Internal Medicine. 2001; 135(3): 221-227.

Physician and Patient Perceptions of Emotional Comfort

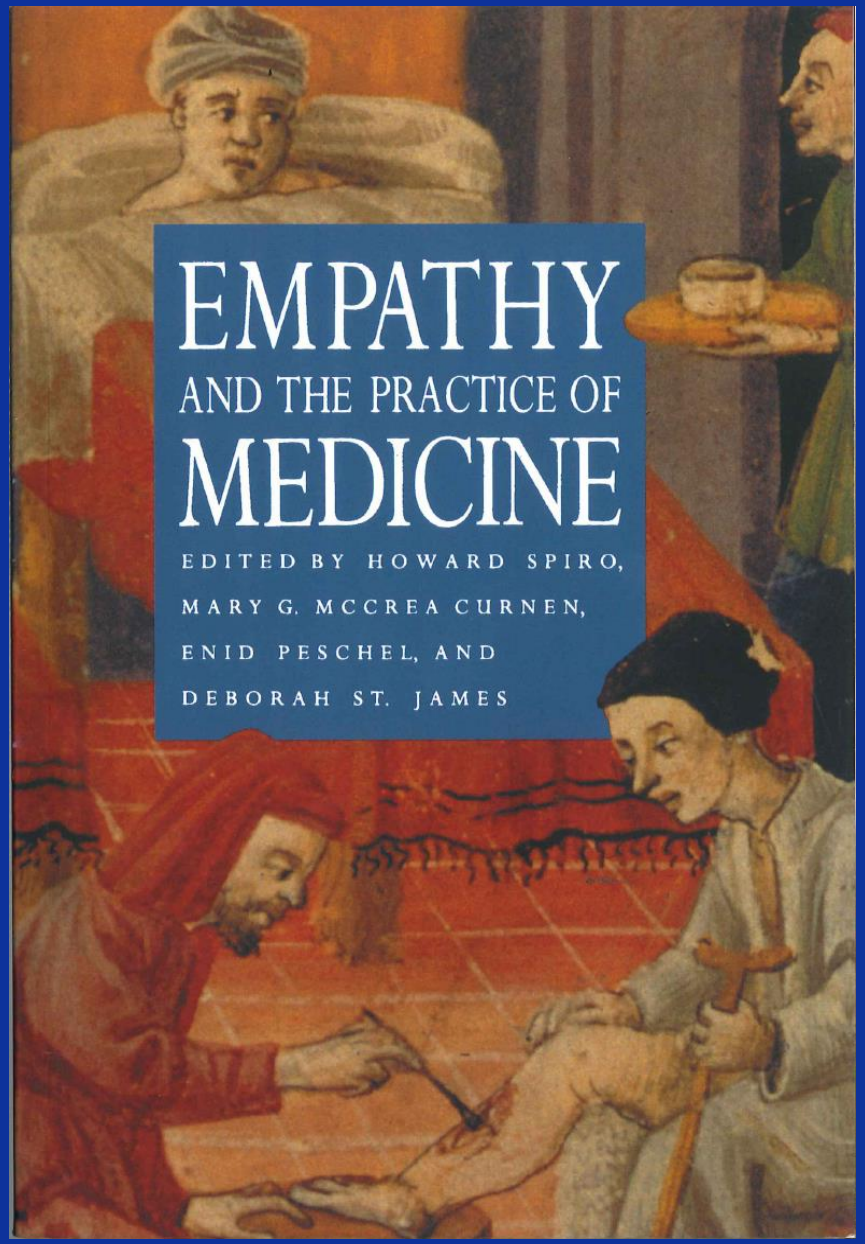


- Creating Patient Context
  - Strategies for developing empathy
  - Tools to develop understanding of patient's history and circumstance
- Making Interactions Meaningful
  - Refining communication and behavioral skills to maximize patient interaction
  - Practicing techniques to build patient rapport

Olson, DP, et al. Communication Discrepancies Between Physicians and Hospitalized Patients. Archives of Intern Medicine. 2010; 170(15): 1302-1307.

"Words matter. What clinicians say and how they say it hugely affects patients."

Pantilat SZ. Better words to say. JAMA 2009; 301(12): 1279-81.

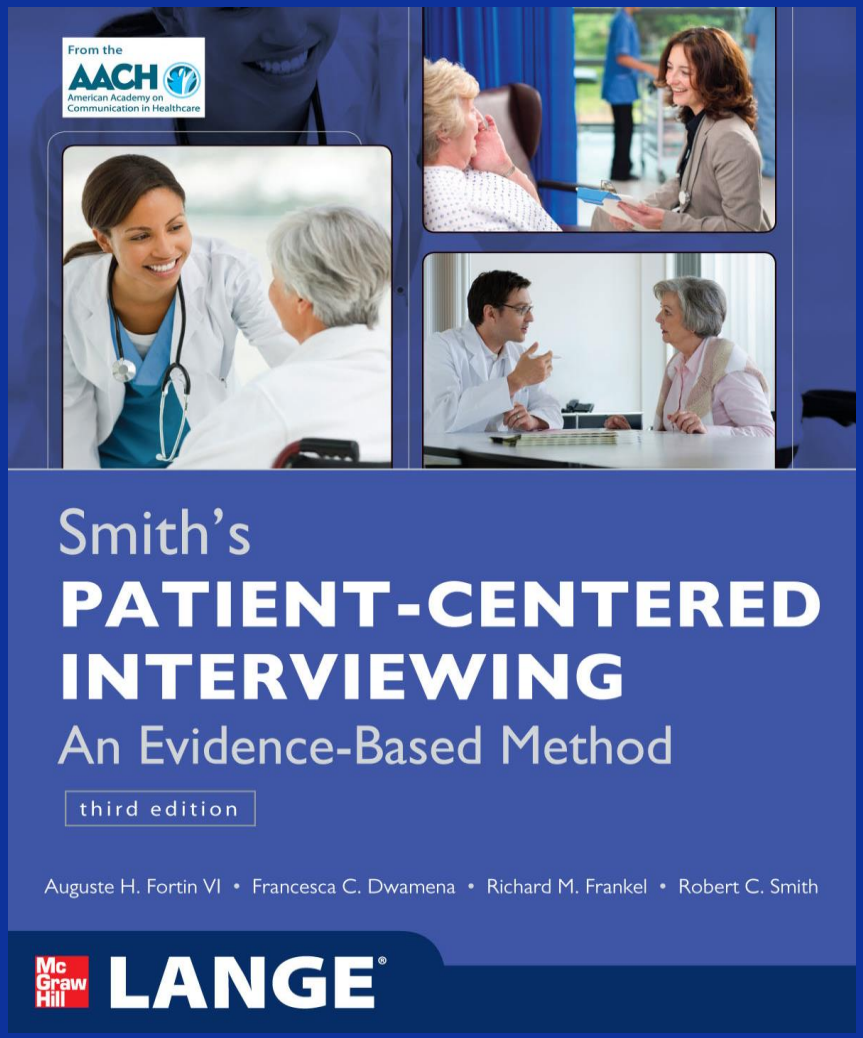


Empathy Training for Physicians

- Three 60 minute empathy modules improved empathic behavior of ENT residents (MGH and Massachusetts Eye & Ear Institute).
  - Improve physician awareness of patients' emotional verbal and nonverbal communications.
  - Respond to these communications with empathic understanding.
  - Increase physician emotional and physiological awareness and self-regulation.
  - Use these skills in challenging patient interactions.
- Meta analysis showed training Oncology Physicians in empathy led to improvement in communication skills and patient outcomes

Riess, H., Kelley JM, et al. Empathy Training for Resident Physicians: A Randomized Controlled Trial of a Neuroscience-Informed Curriculum." Journal General Internal Medicine. Oct. 2012; 27(10): 1280-1286.
Barth, J. et al. Annals of Oncology 22: 1030–1040, 2011.

Teaching
Patient Centered Interviewing



- Symptoms have a personal and emotional context.
- Patients do not want us to fix everything.
- Patients do not often feel our caring and compassion
- Open-ended interviewing skills

The Etiquette of Empathic Behavior

- Easy and Basic principles
  - Ask permission to enter the room
  - Introduce yourself
  - Shake hands
  - Sit down
  - Explain your role on the team
  - Ask the patient how he or she is feeling about being in the hospital

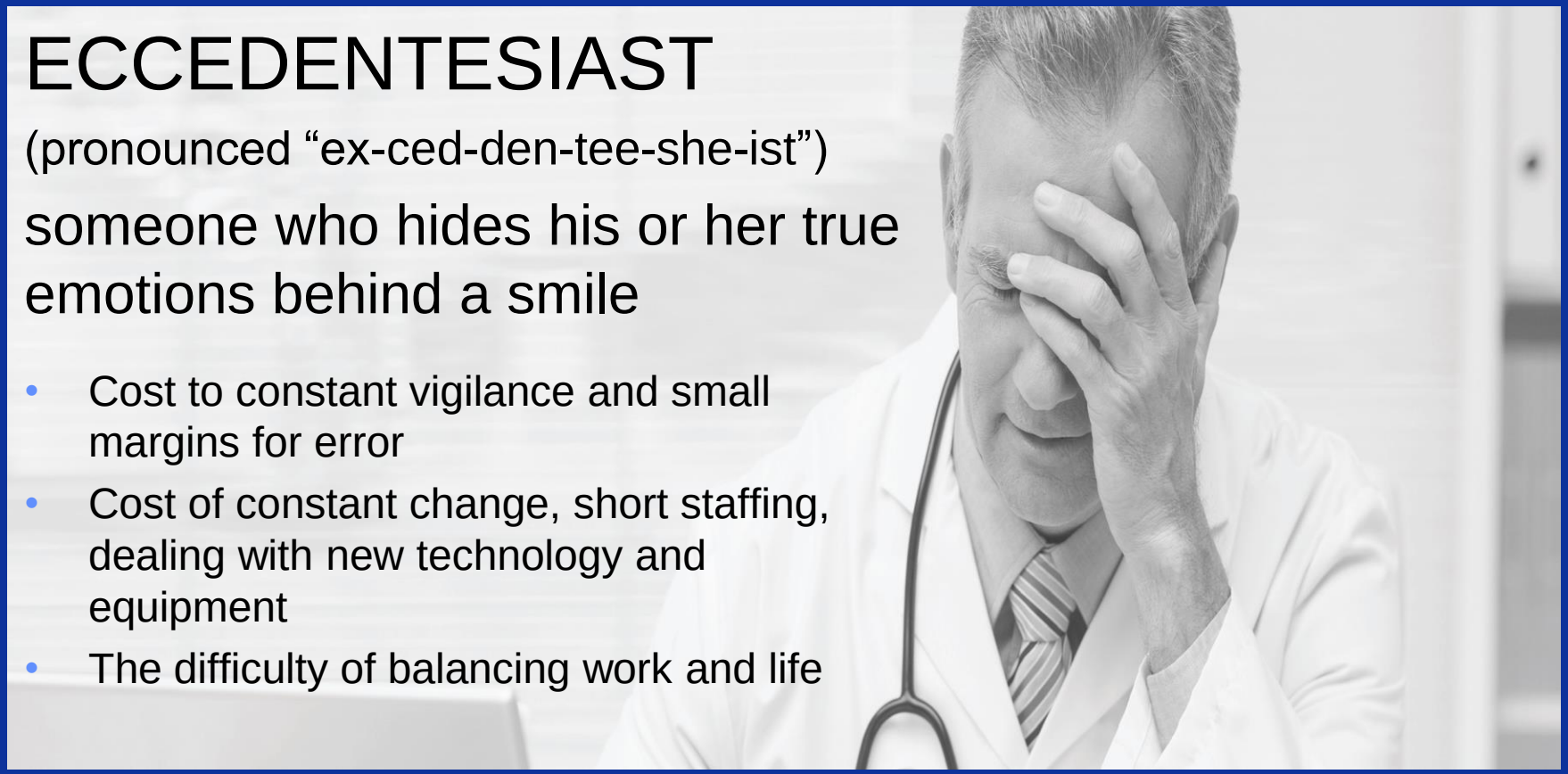
Caution – Avoid being formulaic

Kahn, M. Etiquette-Based Medicine. NEJM 358;1988-1989, May 2008

YNHH Non-Negotiable Behaviors

- 10/5 Rule
  - Make eye contact and smile when within 10 feet of another person
  - Greet them within 5 feet
- AIDET
  - Acknowledge patients by name
  - Introduce yourself and explain your role
  - Offer realistic expectations about the Duration of procedures, tests, or treatments
  - Provide an understandable Explanation of what is happening
  - Thank patients for the information they've shared
- No Venting
  - Refrain from making negative comments or complaints in a public place

The Toll of Emotional Labor:
The Pressure of Maintaining a Priority on Patient Experience



ECCEDENTESIAST

(pronounced “ex-ced-den-tee-she-ist”)

someone who hides his or her true emotions behind a smile

- Cost to constant vigilance and small margins for error
- Cost of constant change, short staffing, dealing with new technology and equipment
- The difficulty of balancing work and life

Tait, D. , et al. Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population. Archives of Internal Medicine. August 20, 2012: E1-E9.
Cricco-Lizza, R. The need to Nurse the Nurse,: Emotional Labor in the Neonatal Intensive Care Unit. *Qual Health Res.*. 2014;24:615-628.

Burnout

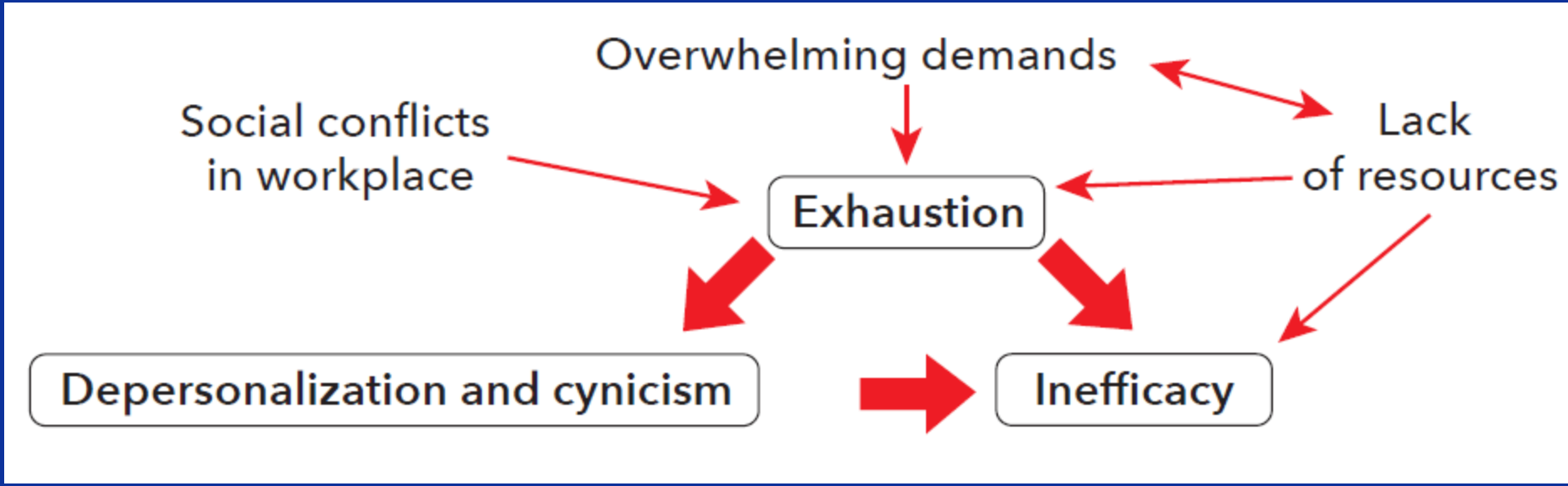
Freudenberger, HJ. Burn-out.: The High Cost of High Achievement. Garden City, NY: Anchor. 1980.

Compassion Fatigue

Joinson, C. Coping with Compassion Fatigue. *Nursing*. 1992; 22(4): 116-120.

Measures of Burnout
Maslach's Burnout Inventory

Maslach, C., Jackson, S.E. and Leiffer, M. P. Maslach's Burnout Inventory Manual. Consulting Psychologists Press. 1981.



- **Emotional exhaustion**: Being emotionally overextended and exhausted by one's work.
- **Depersonalization**: Unfeeling and impersonal responses towards those for whom we care.
- **Inefficacy:** Lack of personal accomplishment; feeling incompetent and unsuccessful in one's work.

A Survey of America's Physicians: Practice Patterns and Perspectives

- Over 75% of physicians are pessimistic or very pessimistic about the future of the medical profession.
- Over 84% of physicians agree that the medical profession is in decline.
- Over 33% of physicians would not choose medicine if they had their careers to do over.
- Over 60% of physicians would retire today if they could.

Hawkins, Merritt. A Survey of America's Physicians: Practice Patterns and Perspectives. Rep. N.p.: Physician's Foundation, 2012.

The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School

- 456 Jefferson Medical College students completed the validated Jefferson Scale of Physician Empathy.
- A significant decline in empathy occurs during the 3rd year of medical school.
- Ironically, when the curriculum shifts to patient care activities and empathy is most essential.

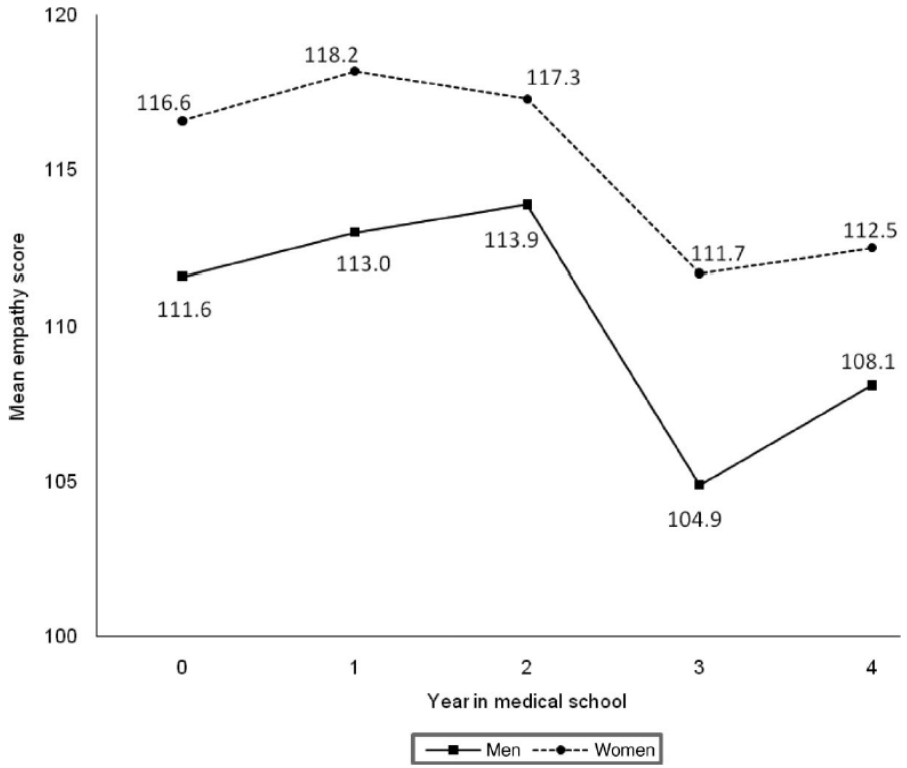


Figure 2 Changes in mean Jefferson Scale of Physician Empathy (JSPE) scores in different years of medical school for 56 men and 65 women who identified themselves at all five administrations of the JSPE ("matched cohort") at Jefferson Medical College, Philadelphia, Pennsylvania, 2002–2008.

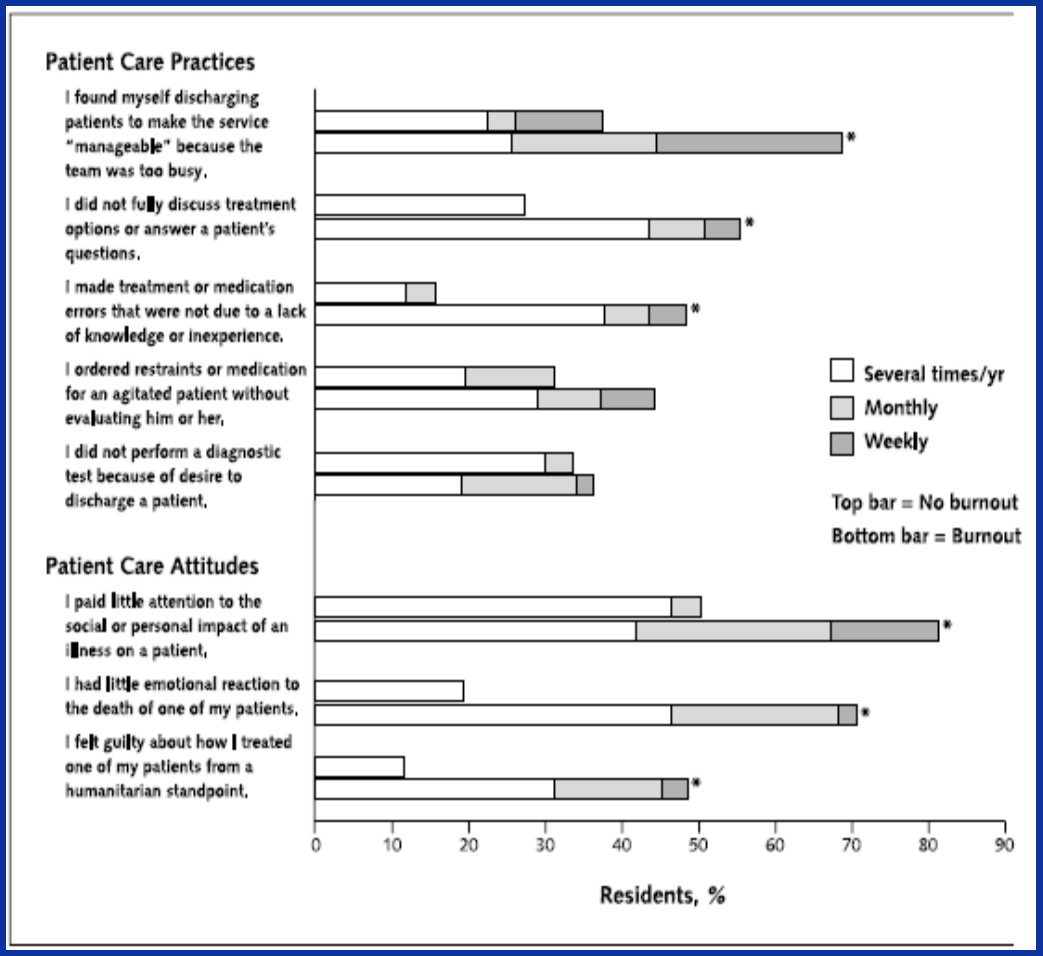
Hojat, M., et al. The Devil is in the Third Year: A Longitudinal Study of Erosion of Empathy in Medical School. Academic Medicine. 2009:84(9); 1182-1191.

The Incidence and Predictors of Job Burnout in First-Year Internal Medicine Residents: A Five-Institution Study

- 5 Institution Study: Yale, U of P, MGH, Brigham and Women's, Mount Sinai and Weill Cornell.
- 263 first-year residents (2008-2009) were eligible and given surveys at the start and end of internship year.
- 185 (70%) completed both surveys.
  - 114/185 (62%) were free of burnout **at the start**
  - 86/114 (75%) **ended the year with burnout**
- No statistical relationship to gender, work hours, debt, depression, social supports
- **Meaningful feedback may prevent burnout**.

Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program

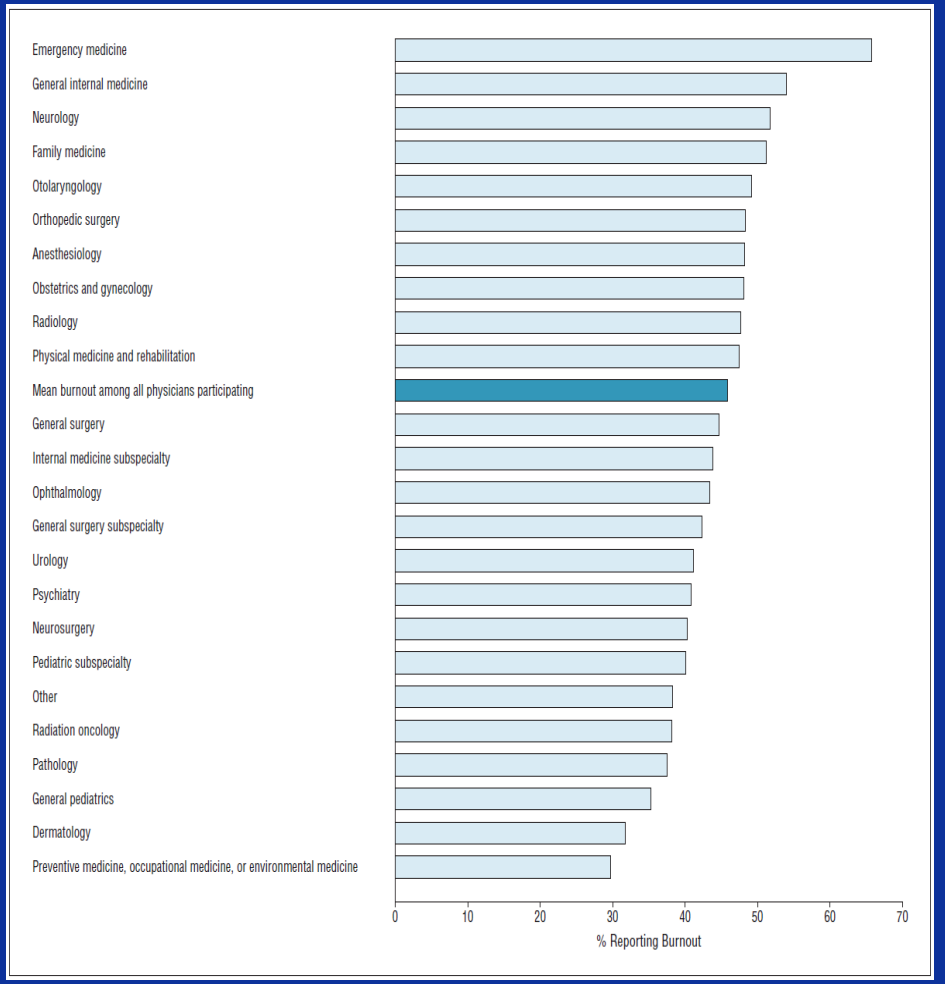
- 87 of the 115 (76%) residents at the University of Washington responded met the Maslach criteria for burnout.
- Burnout was strongly associated with self reports of one or more sub-optimal patient care practices at least monthly.



Shanafelt, T.D., Bradley, K.A., Wipf, J.E. and Back, A.L. Burnout and Self-Reported Patient Care in an Internal Medicine Residency Program. Annals of Internal Medicine. 2002; 136:358-367.

Burnout and Satisfaction with Work-Life Balance Among US Physicians Relative to the General US Population

- 27,270 physicians were surveyed
- 7,288 (26.7) responded
- 46% of physicians reported at least one symptom of burnout.
  - » Emotional exhaustion
  - » Depersonalization
  - » Low sense of accomplishment
- General Internal Medicine was 2nd only to Emergency Medicine.



Shanafelt, T.D., et al. Archives of Internal Medicine. Published online. August 20, 2012. E1-E9.

Clinical Empathy as Emotional Labor in the Patient-Physician Relationship

Larson, EB and Yao, X. JAMA. March 2, 2005. 293(9); 1100-1106.

THE PATIENT-PHYSICIAN RELATIONSHIP

Clinical Empathy as Emotional Labor in the Patient-Physician Relationship

Eric B. Larson, MD, MPH
Xin Yao, PhC

Empathy should characterize all health care professions. Despite advancement in medical technology, the healing relationship between physicians and patients remains essential to quality care. We propose that physicians consider empathy as emotional labor (ie, management of experienced and displayed emotions to present a certain image). Since the publication of Hochschild's *The Managed Heart* in 1983, researchers in management and organization behavior have been studying emotional labor by service workers, such as flight attendants and bill collectors. In this article, we focus on physicians as professionals who are expected to be empathic caregivers. They engage in such emotional labor through deep acting (ie, generating empathy consistent emotional and cognitive reactions before and during empathic interactions with the patient, similar to the methods of acting traditions used by some stage and screen actors), surface acting (ie, forging empathic behaviors toward the patient, absent of consistent emotional and cognitive reactions), or both. Although deep acting is preferred, physicians may rely on surface acting when immediate emotional and cognitive understanding of patients is impossible. Overall, we contend that physicians are more effective healers—and enjoy more professional satisfaction—when they engage in the process of empathy. We urge physicians and others to recognize that their work has an element of emotional labor and, second, consciously practice deep and surface acting to empathize with their patients. Medical students and residents can benefit from long-term regular training that includes conscious efforts to develop their empathic abilities. This will be valuable for both physicians and patients facing the increasingly instrumented and technological world of modern medicine.

JAMA. 2005;293:1100-1106 www.jama.com

Interest in the relationship between physicians and patients is as old as the practice of medicine. Over the past 20 years, scholarly interest has increased as educators and practicing professionals have realized that a therapeutic relationship, along with integration of knowledge and skills, content of care, information management, teamwork, and health systems[1-3] is an integral part of healing and effective medical care.[4,5] The *context effect*, better known as the placebo effect, addresses in greatest detail the impact of the patient-physician relationship on a patient's recovery.[6]

The published literature suggests that physicians who display a warm, friendly, and reassuring manner with their patients are more effective.[7] In addition, Halpern[8] wrote that empathy (1) makes patients more forthcoming about their symptoms and concerns, thus, facilitating medical information gathering, which, in turn, yields more accurate diagnosis and better care; (2) helps patients regain autonomy and participate in their therapy by increasing their self-efficacy; and (3) leads to therapeutic interactions that directly affect patient recovery.[8] In sum, "making connexions"[9] and developing empathy are fundamental to caring and enhance the therapeutic potential of patient-clinician relationships.[10,11]

Given the need for empathy as part of effective treatment, physicians have to learn to empathize with their patients. To cultivate an acute ability to empathize with others, one needs patience, curiosity, and willingness to subject one's mind to the patient's world.[8] However, there are many obstacles that contemporary physicians face as they aspire to develop empathy. These include a demanding work environment with heavy workloads,[12] little importance attached to empathy,[13] and cynicism.[14] In addition, research indicates insufficient training and education in compassion and emotional aspects of health care for various health professionals.[15,16] We believe that better understanding of empathy—and more importantly, framing the psychological and behavioral activities in this process as acting methods used in emo-

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The Patient-Physician Relationship Section Editor: Richard M. Glass, MD, Deputy Editor.

We propose that physicians consider **empathy as emotional labor** (ie., management of experienced and displayed ***emotions to present a certain image***)

Surface acting - the process of displaying behaviors consistent with required emotions but ***associated with burnout***.

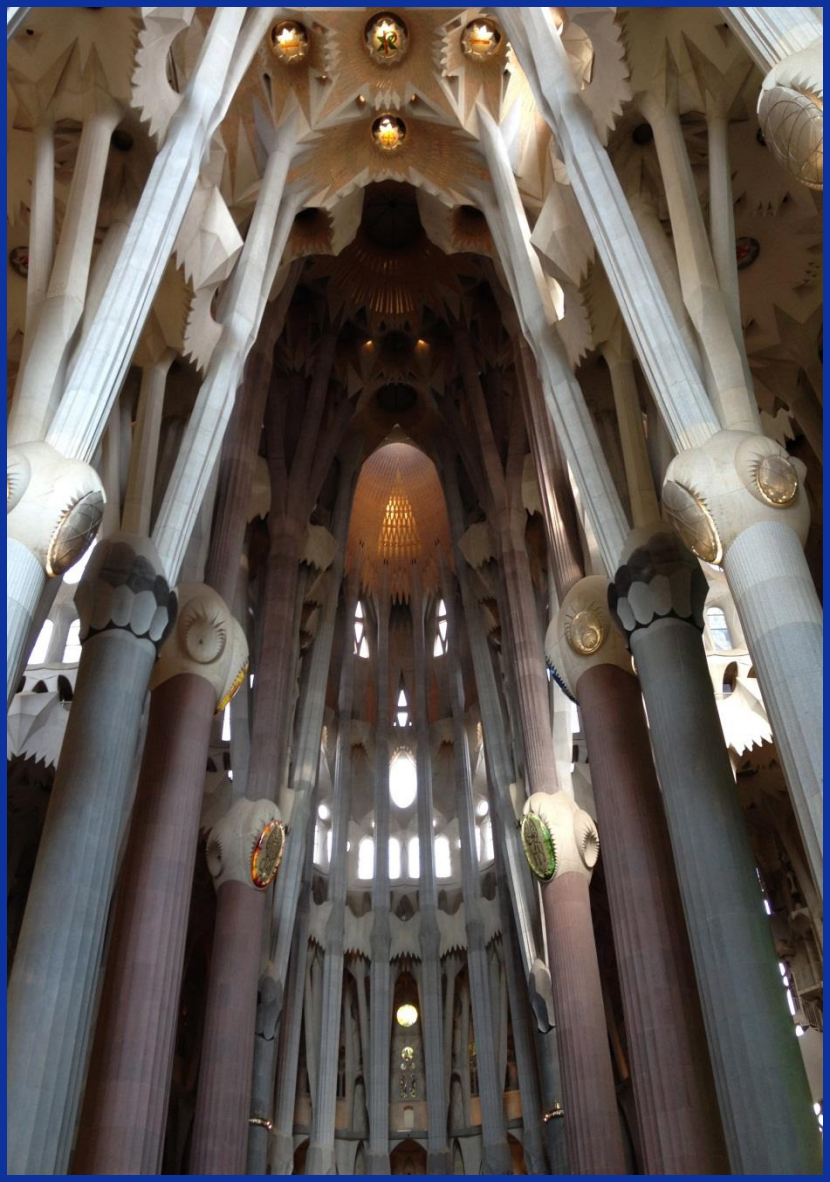
Deep Acting – the creation of an internal emotional state that allows for empathic presence with our patients and ***associated with professional satisfaction***.

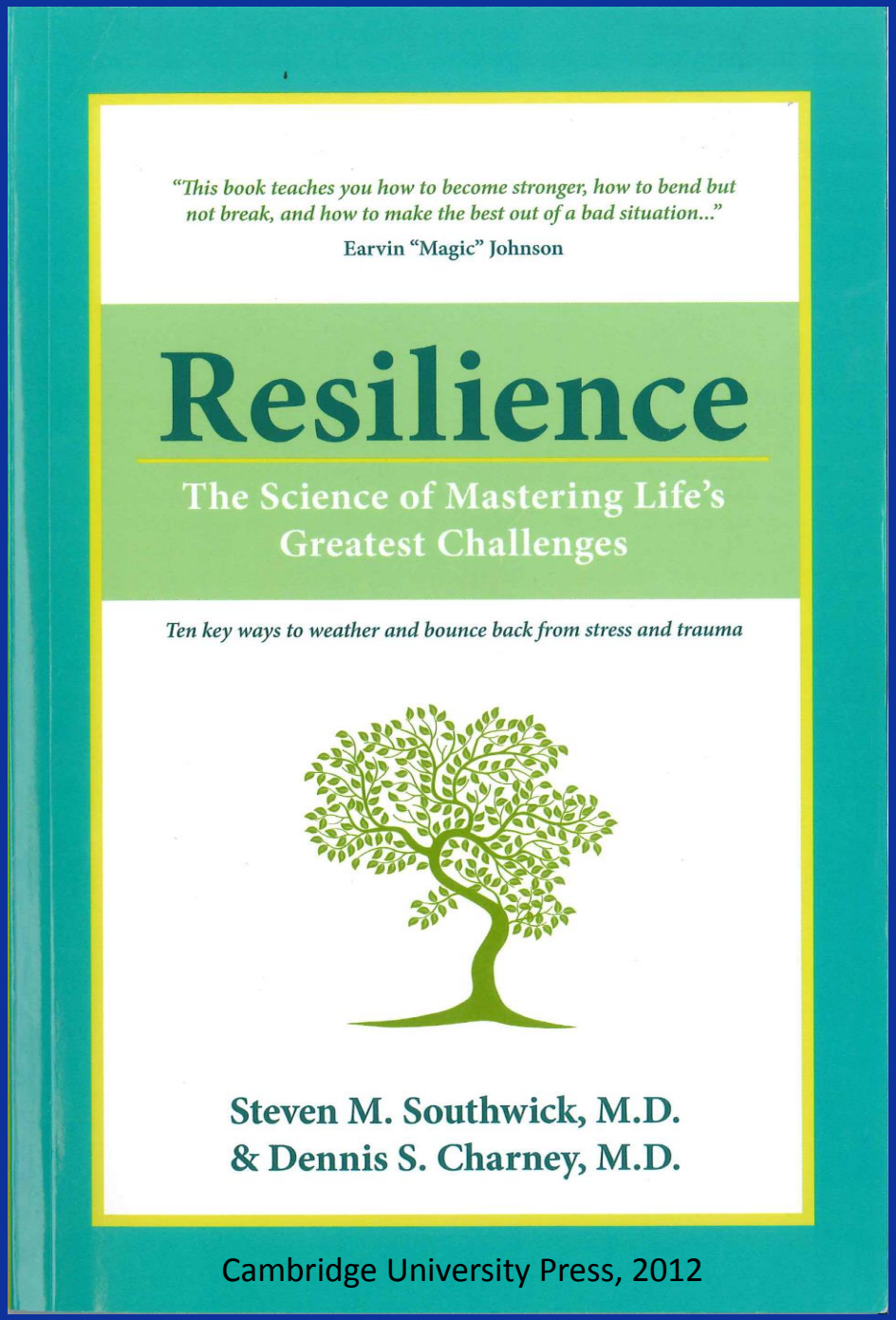
La Sagrada Familia

By Antoni Gaudi

Tensile Strength

Compressile Strength





- "The forces of fate that bear down on man and threaten to break him also have the capacity to ennoble him."
  Elisabeth S. Lukas, protégé of Viktor Frankl, psychiatrist and Holocaust survivor

- Resilience – the capacity to bend without breaking
  - The ability to bounce back from the brink of despair, grow in the process and become more compassionate and dedicated.

- Resilience factors:
  - Realistic optimism
  - Facing fear
  - Moral compass
  - Religion & spirituality
  - Social Support
  - Resilient Role Models
  - Physical & cognitive fitness
  - Cognitive and emotional flexibility
  - Meaning and purpose

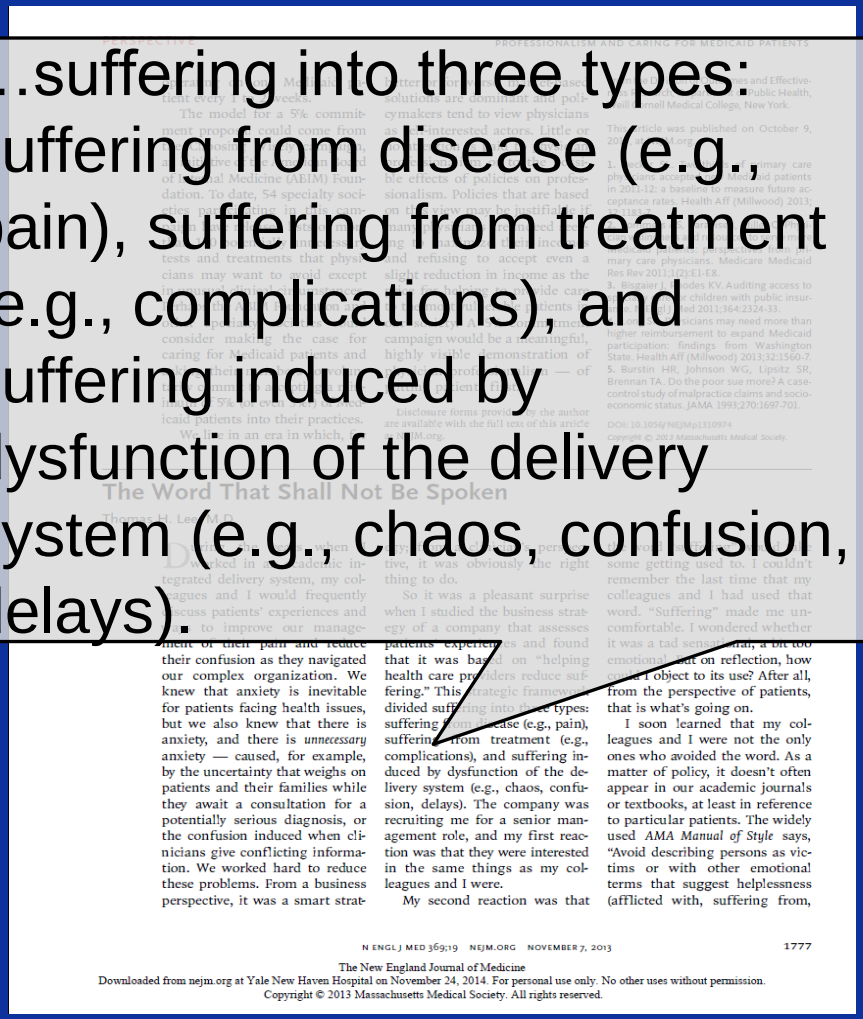
Report of the Roundtable on Joy and Meaning in Work and Workforce Safety

1. Am I treated with dignity and respect by everyone?
2. Do I have what I need so I can make a contribution that gives meaning to my life?
3. Am I recognized and thanked for what I do?

Paul O'Neill
Former CEO of Alcoa

Lucian Leape Institute **2013**

Suffering and Creating an Epidemic of Empathy



…suffering into three types: suffering from disease (e.g., pain), suffering from treatment (e.g., complications), and suffering induced by dysfunction of the delivery system (e.g., chaos, confusion, delays).

The Word That Shall Not Be Spoken

their confusion as they navigated our complex organization. We knew that anxiety is inevitable for patients facing health issues, but we also knew that there is anxiety, and there is *unnecessary* anxiety — caused, for example, by the uncertainty that weighs on patients and their families while they await a consultation for a potentially serious diagnosis, or the confusion induced when clinicians give conflicting information. We worked hard to reduce these problems. From a business perspective, it was a smart strat-

health care pr… fering." This … divided suffering into three types: suffering from disease (e.g., pain), suffering from treatment (e.g., complications), and suffering induced by dysfunction of the delivery system (e.g., chaos, confusion, delays). The company was recruiting me for a senior management role, and my first reaction was that they were interested in the same things as my colleagues and I were.

My second reaction was that

some getting used to. I couldn't remember the last time that my colleagues and I had used that word. "Suffering" made me uncomfortable. I wondered whether it was a tad sensational, a bit too emotional. But on reflection, how could I object to its use? After all, from the perspective of patients, that is what's going on.

I soon learned that my colleagues and I were not the only ones who avoided the word. As a matter of policy, it doesn't often appear in our academic journals or textbooks, at least in reference to particular patients. The widely used *AMA Manual of Style* says, "Avoid describing persons as victims or with other emotional terms that suggest helplessness (afflicted with, suffering from,

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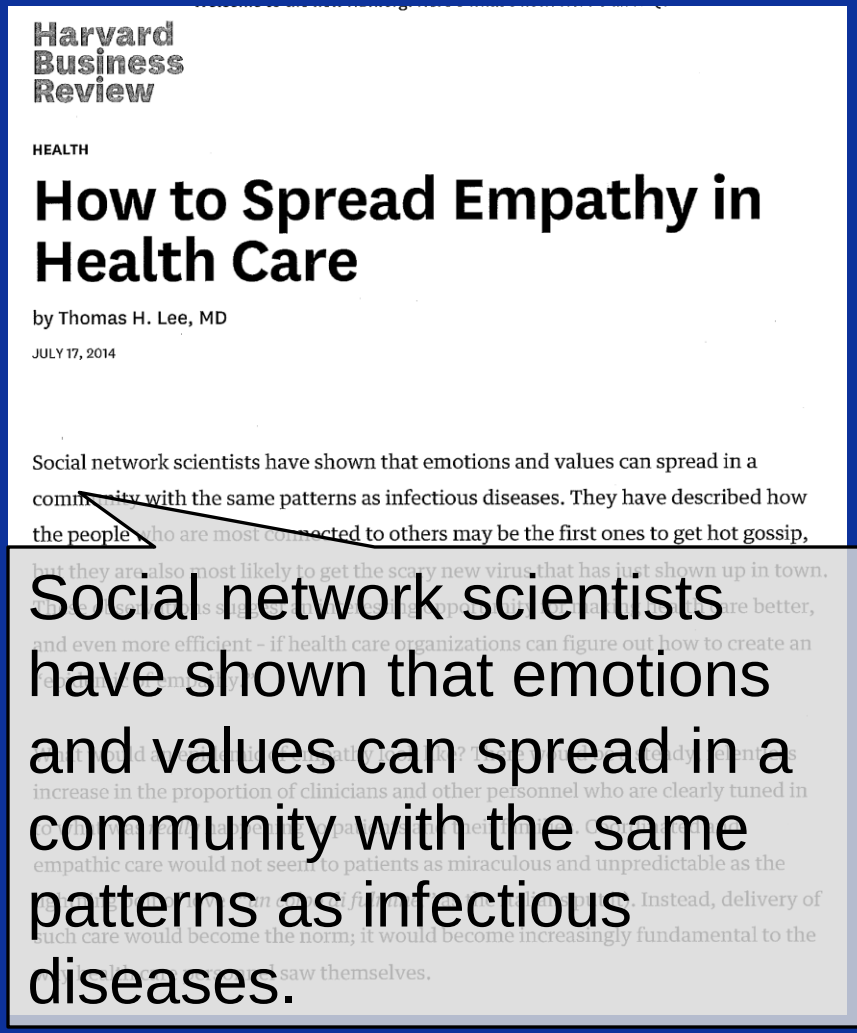


Harvard Business Review

HEALTH

How to Spread Empathy in Health Care

by Thomas H. Lee, MD

JULY 17, 2014

Social network scientists have shown that emotions and values can spread in a community with the same patterns as infectious diseases. They have described how the people who are most connected to others may be the first ones to get hot gossip, but they are also most likely to get the scary new virus that has just shown up in town.

Social network scientists have shown that emotions and values can spread in a community with the same patterns as infectious diseases.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Spread of Obesity in a Large Social Network over 32 Years

Nicholas A. Christakis, M.D., Ph.D., M.P.H., and James H. Fowler, Ph.D.

ABSTRACT

BACKGROUND

The prevalence of obesity has increased substantially over the past 30 years. We performed a quantitative analysis of the nature and extent of the person-to-person spread of obesity as a possible factor contributing to the obesity epidemic.

METHODS

We evaluated a densely interconnected social network of 12,067 people assessed repeatedly from 1971 to 2003 as part of the Framingham Heart Study. The body-mass index was available for all subjects. We used longitudinal statistical models to examine whether weight gain in one person was associated with weight gain in his or her friends, siblings, spouse, and neighbors.

RESULTS

Discernible clusters of obese persons (body-mass index [the weight in kilograms divided by the square of the height in meters], ≥30) were present in the network at all time points, and the clusters extended to three degrees of separation. These clusters did not appear to be solely attributable to the selective formation of social ties among obese persons. A person's chances of becoming obese increased by 57% (95% confidence interval [CI], 6 to 123) if he or she had a friend who became obese in a given interval. Among pairs of adult siblings, if one sibling became obese, the chance that the other would become obese increased by 40% (95% CI, 21 to 60). If one spouse became obese, the likelihood that the other spouse would become obese increased by 37% (95% CI, 7 to 73). These effects were not seen among neighbors in the immediate geographic location. Persons of the same sex had relatively greater influence on each other than those of the opposite sex. The spread of smoking cessation did not account for the spread of obesity in the network.

CONCLUSIONS

Network phenomena appear to be relevant to the biologic and behavioral trait of obesity, and obesity appears to spread through social ties. These findings have implications for clinical and public health interventions.

From the Department of Health Care Policy, Harvard Medical School, Boston (N.A.C.); the Department of Medicine, Mt. Auburn Hospital, Cambridge, MA (N.A.C.); the Department of Sociology, Harvard University, Cambridge, MA (N.A.C.); and the Department of Political Science, University of California, San Diego, San Diego (J.H.F.). Address reprint requests to Dr. Christakis at the Department of Health Care Policy, Harvard Medical School, 180 Longwood Ave., Boston, MA 02115, or at christakis@hcp.med.harvard.edu.

N Engl J Med 2007;357:370-9.

12,067 assessed repeatedly from 1971 - 2003 as part of the FHS. Weight gain in one person was associated with weight gain with his friends, siblings, spouse and neighbors.

Clusters of obese persons were present in the network at all time points and the clusters extended to 3 degrees of separation.

Network phenomenon appears to be relevant to biological and behavioral traits.

Statistics
in Medicine

Featured Article

Received 22 November 2011, Accepted 21 February 2012 Published online 18 June 2012 in Wiley Online Library

(wileyonlinelibrary.com) DOI: 10.1002/sim.5408

Social contagion theory: examining dynamic social networks and human behavior

Nicholas A. Christakis[a,b*†] **and James H. Fowler**[c,d]

Here, we review the research we have conducted on social contagion. We describe the methods we have employed (and the assumptions they have entailed) to examine several datasets with complementary strengths and weaknesses, including the Framingham Heart Study, the National Longitudinal Study of Adolescent Health, and other observational and experimental datasets that we and others have collected. We describe the peculiarities that led us to propose that human social networks may exhibit a 'three degrees of influence' property, and we review statistical approaches we have used to characterize interpersonal influence with respect to phenomena as diverse as

We describe the methods and statistics that lead us to propose that human **social networks may exhibit a 'three degrees of influence' property**, to characterize interpersonal influence with respect to phenomena as diverse as **obesity, smoking, cooperation, and happiness**. We believe this provides novel informative and stimulating evidence regarding social contagion in longitudinally followed networks.

1. Introduction

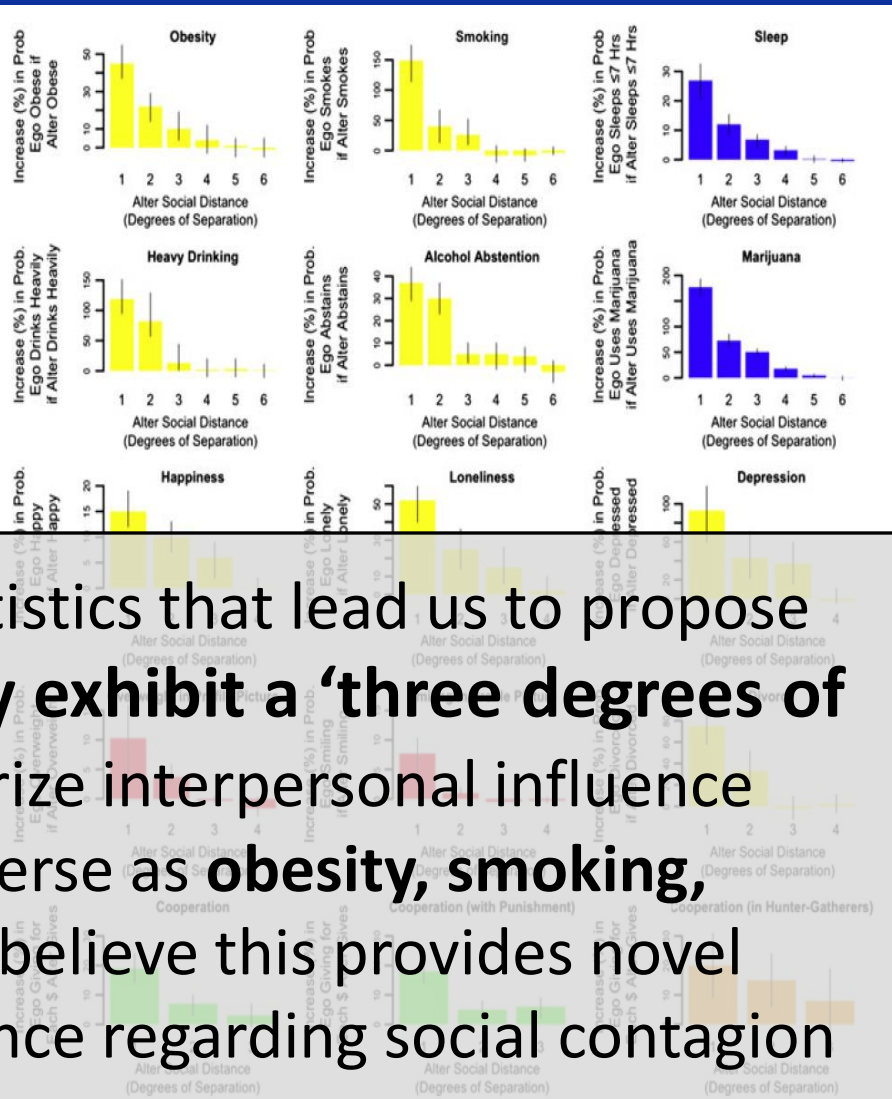


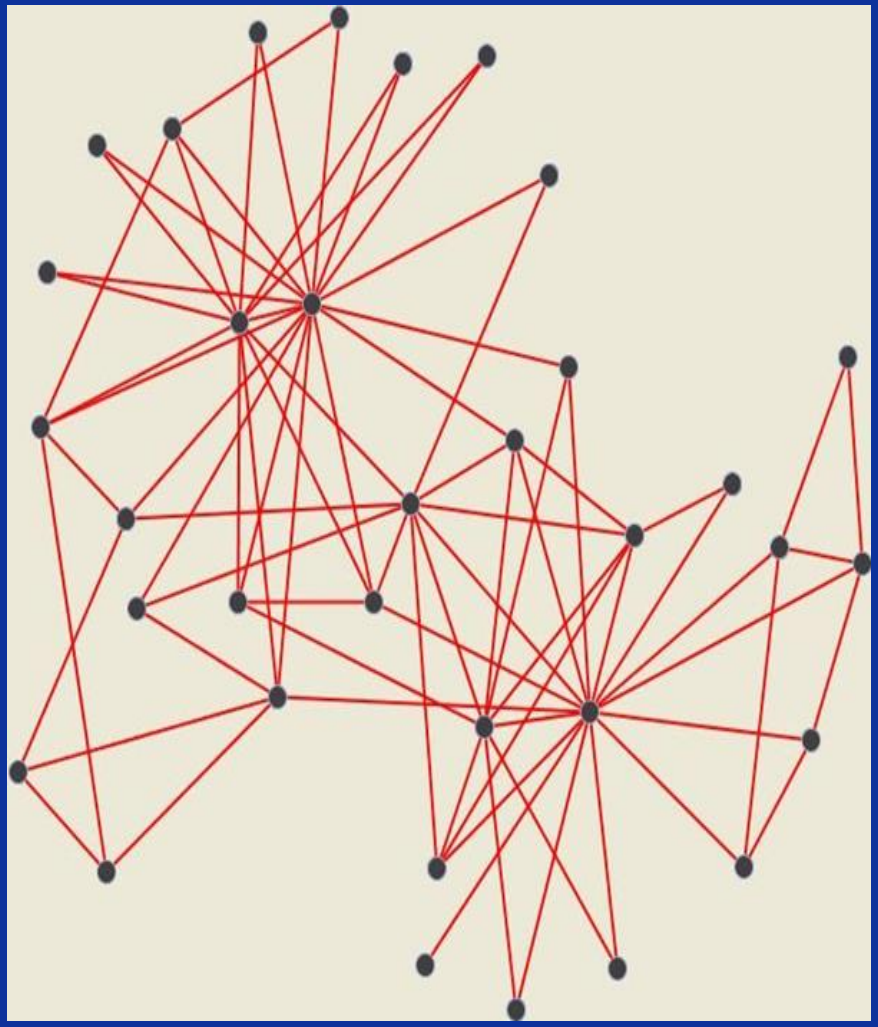
Figure 1. Results from network permutation tests, using five different observational and experimental datasets, show significant associations up to between 2 and 4 degrees of separation for a variety of 15 different behaviors and affective states. The Y axis represents the percentage increase in probability that an ego has the trait of interest given that an alter has it, compared with the probability that an ego has the trait given that the alter does not have it. Vertical black lines indicate 95% confidence intervals. For more details, see the related manuscripts cited in the text. Colors indicate data source: yellow: Framingham Heart Study Social Network [14]; blue: AddHealth [1]; green: lab experiment [6]; red: Facebook strong ties [2]; orange: Hadza hunter gatherers [5].

networks or influence paths were artificially created [3, 6, 7] — to examine various network phenomena. These datasets have complementary strengths and weaknesses, as do the various analytic approaches we have employed.

There are two broad classes of investigations of networks that we have undertaken: studies of network topology (and its determinants), and studies of the spread of phenomena across network ties. Although we have done work on the former [5, 7–13], here we will focus primarily on the latter, discussing analyses of the flow of behaviors, affective states, or germs. Our work on social networks and human behavior

The Potential of Social Networks to Spread Empathy

- Norms and behaviors are influenced by our friends, our friends' friends, and our friends', friends' friends.
- Network science suggests that the behavior of the network can sometimes explain more than the behavior of an individual actor.
- Can we use individuals to set off a network response of empathy?



Schwartz Rounds

"Pay It Forward"

Reprinted courtesy of the Kenneth B. Schwartz Center

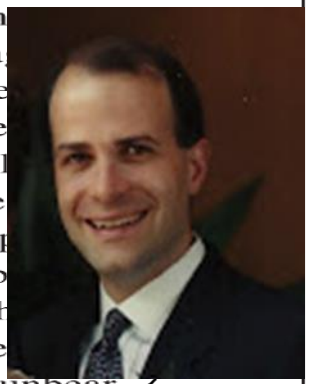
The Boston Globe Magazine

July 16, 1995

I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness – the simple human touch from my caregivers – have made the unbearable bearable.

A PATIENT'S STORY

UNTIL LAST FALL, I had spent a considerable part of my [illegible] and then in the private sector. I came to know a lot about health-care policy and management, government regulations and contracts. But I knew little about the delivery of care. All that changed on November 7, 1994, when [illegible] I was diagnosed with advanced cancer. In the months that followed, I was subjected to chemotherapy, radiation, surgery, and news of all most of it bad. It has been a harrowing experience and yet, the ordeal has been elevated by exquisite compassion. I have been the recipient of an extraordinary array of human and humane responses to my plight. These acts of kindness – the simple human touch from my caregivers – have made the unbearable



The author (seated) with Dr. Thomas Lynch, an oncologist at Massachusetts General Hospital.

Schwartz Center for Compassionate Care

ORIGINAL CONTRIBUTION — CLINICIAN'S CORNER

Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians

Research — Original Investigation

Intervention to Promote Physician Well-being, Job Satisfaction, and Professionalism
A Randomized Clinical Trial

Colin P. West, MD, PhD; Liselotte N. Dyrbye, MD, MHPE; Jeff T. Rabatin, MD, MSc; Tim G. Call, MD; John H. Davidson, MD; Adamarie Multari, MD; Susan A. Romanski, MD; Joan M. Henriksen Hellyer, RN, PhD; Jeff A. Sloan, PhD; Tait D. Shanafelt, MD

IMPORTANCE Despite the documented prevalence and clinical ramifications of physician distress, few rigorous studies have tested interventions to address the problem.

OBJECTIVE To test the hypothesis that an intervention involving a facilitated physician small-group curriculum would result in improvement in well-being.

Invited Commentary page 533
Supplemental content at jamainternalmedicine.com
CME Quiz at jamanetworkcme.com and CME Questions page 656

Growing body of research suggest enhancing meaning in work increases physician satisfaction and reduces burnout.

Dedicated time supporting mindfulness, reflection, shared experience and small group learning results in significant lasting improvements in burnout, mood disturbances, and empathy.

Krasner MS, Epstein RM, Beckman H, et al. Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293

West, CP, Shanafelt, TD, et al. Intervention to Promote Physician Well-being and Professionalism. A randomized clinical trial. JAMA, published online February 10, 2014

Press Ganey National Client Conference Video Featuring Yale-New Haven Hospital

The idea that love is the "secret of quality" in healthcare which might be viewed skeptically…

Current changes in the practice of medicine, while offering important benefits to patients, have the potential to empty physicians' buckets. Pay-for-performance, residency work hour restrictions, electronic medical records, constant hospital renovations causing disruption and slow elevators, all represent change—and change is difficult.

…it was our experiences with patients that resonated most when we thought about love in our careers. Each of us identified the core mission of medicine, **making a meaningful difference in someone else's life—healing if possible, alleviating suffering and fear if not, or simply caring—as the ingredient that filled our buckets.**

Press, MJ, Judson, TJ, Detsky, AS. Filling Buckets. JAMA, May 2014; 311(18): 1859-1860.

YALE-NEW HAVEN HOSPITAL

Yale SCHOOL OF MEDICINE

● Shared vision ● Different perspective ● Common goal

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.”

- Margaret Mead

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- My Assistant: Lisa Spearman
- My Wife: Jennifer Bennick

- **Special thanks: the Beryl Institute for Patient Experience, the Gold Humanism Foundation, and Press Ganey**