MAKING THE PATIENT YOUR PARTNER

Communication Skills for Doctors and other Caregivers

Thomas Gordon, W. Sterling Edwards

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W. STERLING EDWARDS, M.D.

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Preface

This book is written for all health professionals who relate directly to patients, such as doctors, nurses, psychologists, hospital chaplains, and social workers. It is also a book for all others who give care to the ill: hospital and hospice volunteers, nursing home personnel, spouses, families, and friends. The focus of the book is on improving the way such persons communicate with patients.

The authors have come to believe that it is possible for caregivers, both professional and nonprofessional, to help the sick person feel respected, supported, and trusted at every stage of the patient's illness—whether that critical first visit to the physician's office, the emotional anguish when submitting to various diagnostic procedures, extended confinement in a hospital, a prolonged struggle with a life-threatening illness, or facing the inevitability of death.

In spite of the tremendous medical advances that have been made in the 20th century, there are still many illnesses that cannot be "cured" by medical means and some that can only be controlled by lifelong treatment. It is disappointing that medicine seems to have made little progress, or, as some believe, even to have gone backward in dealing with the emotional components of serious illness. The old family doctor had an image of being more empathic than the modern medical specialist, but perhaps this was because empathy was the main tool he had. Only now are we beginning to realize how valuable that emotional support can be.

Countless studies have shown that a large percentage of patients become dissatisfied with their relationships with health professionals. And the source of that dissatisfaction is seldom the technical incompetence of the health professional. More often it is the ineffectiveness of the communication between them. Most patients don't feel encouraged to ask questions or talk about all that's bothering them, and they are often unclear about what the health professional tells them. Research studies employing tape recordings of the medical interview show frequent interruptions of patients and little empathy.

For the nonprofessional caregivers—spouses, families, friends—a serious illness is almost as disruptive as if they were the patient. Beginning with the onset of symptoms and the diagnosis, there is anxiety and fear of the unknown. Most people have no experience coping with the emotional changes in the patient, let alone recognizing and dealing with their own feelings. And most laypeople don't have the necessary communication skills to help patients talk about their problems or openly express their feelings.

The intent of the authors of this book is not to condemn or blame either health professionals or nonprofessional caregivers, for we recognize that inadequate interpersonal communication is also the rule rather than the exception with parents, teachers, lawyers, managers, salespeople, and almost any other group you can think of. This is because only recently has interpersonal communication become a field of study for social scientists and medical researchers. Their studies have clearly identified specific communication skills that strengthen relationships and those that weaken them. Certain kinds of talk can actually be therapeutic—helping people deal constructively with their negative emotions, find solutions to their problems, take control of their lives.

These "helping skills" can be particularly useful for *anyone* relating to patients. The authors found abundant research evidence showing that patients who experience effective two-way communication with their health professional are more satisfied with their treatment, less inclined to initiate a malpractice suit, recover more quickly from surgery, and more likely to comply with the physician's treatment regime.

Nurses, social workers, hospice volunteers, and hospital chaplains are sometimes more attuned to the patient's feelings than are physicians. However, many of them are not aware that certain often-used verbal messages can be roadblocks to patients' communication, and that there are new and more effective ways to enhance relationships with patients.

It is possible for caregivers, both professional and nonprofessional to learn how to help the sick find peace, hope, and meaning in life regardless of the course of the physical part of the illness. Relationships with patients can become like a partnership with mutual support, respect, and trust.

The first chapter of the book provides evidence for the frequency of patients' dissatisfaction with their relationships with health professionals. It also documents the widespread recognition of this problem by physicians themselves and identifies the potential benefits to be derived from better communication between physicians and patients.

Chapters 2–6 and 12 were written by Dr. Gordon, who first makes a strong case for health professionals to adopt a new "relationship model" that is less paternalistic and more collaborative. Then Dr. Gordon presents the communication skills needed to build such relationships. These critical interpersonal skills are illustrated by interactions and dialogues, primarily between patients and their doctors or nurses.

Chapters 7–11, written by Dr. Edwards, focus on the special problems and needs of patients with chronic and life-threatening illnesses, and then illustrate the use of the interpersonal communication skills in relating to such patients. In these chapters the communication skills are illustrated by interactions and dialogues primarily between patients and those persons who most often care for them—such as hospice volunteers, counselors, nursing home personnel, spouses, family members, friends, and other caregivers.

Every one of us may become a caregiver at some point for a family member or a friend who is ill. The authors hope this book will be of help not only to health professionals but also to those caregivers who would like to empower patients to deal more constructively with their pain, their loneliness, their fears, and hopes.

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Introduction

Thomas Gordon, Ph.D.

For 40 years my principal professional activity has been trying to identify the key interpersonal communication skills that foster satisfying and healthy relationships, and then developing effective ways to teach them to others.

My training in client-centered psychotherapy and a long association with its innovator, Carl Rogers, convinced me that the professional therapist's chief therapeutic tool, empathic and nonjudgmental "reflection of feelings," would be valuable to other professionals, such as teachers, clergy, personnel counselors, social workers—any member of a "helping profession." However, it was not until later, when I served as a psychological consultant to an industrial organization, that I discovered that this potent therapeutic skill could also be learned and utilized by managers and supervisors to foster better two-way communication with workers and build close and productive relationships with them.

This consulting experience launched me into a period of doing leadership training, during which I was to learn that other communication skills besides empathic listening were necessary for leaders to create a "therapeutic climate" for their group members. One of these interpersonal skills was authentic and nonevaluative self-disclosure—being open, honest, and direct in communicating thoughts, feelings, and concerns to others. I coined the term "I-Message" for this essential skill. Another skill leaders needed was group-centered problem-solving—getting workers to participate actively

with their leader in solving work-related problems or setting rules and policies.

These early leadership training experiences influenced me to write my first book, *Group-Centered Leadership: A Way of Releasing the Creative Power of Groups*. Unfortunately, neither my colleagues nor many organizations were open to this collaborative and democratic model of leadership, which 20 years later would be called "participative management" and be widely taught in business schools and used by most of the Fortune 500 companies.

My next application of these critical interpersonal skills was in parent–child relationships. I designed a brief eight-session course and called it Parent Effectiveness Training (P.E.T.). I authorized other instructors to teach it, and within 10 years several thousand instructors were teaching P.E.T. in every state. As of this writing P.E.T. is taught in 37 countries, and well over a million persons have learned empathic listening (now called Active Listening), I-Messages, participative problem-solving and a fourth skill, called No-Lose Conflict Resolution.

By now, the benefits of these skills have been confirmed by a large body of research. The P.E.T. course alone has been evaluated in 60 or more research studies. Even more gratifying is the fact that my organization, Effectiveness Training International, coordinates a worldwide network of several thousand instructors teaching parents, leaders, teachers, clergy, social workers, counselors, nurses, and doctors.

Some years ago, Dr. Richard Feinbloom, a Harvard-trained pediatrician and author of the *Child Health Encyclopedia*, delivered an invited lecture at our national convention of Effectiveness Training instructors. His words were prophetic:

> There is a growing challenge to the disease model of illness. . . . Under what I call the facilitative model of medical practice, the doctor and patient are each persons in their own right, each with different information. The patient is a full partner in the management of his illness. . . . The doctor can increase the chances of being used as a consultant if he can first ally himself with the emotional needs of the patient through the process which you call Active Listening. . . . Thus the professional must increasingly become interested in how to help someone change his attitudes and modify his behavior. These goals require a far different set of skills than those traditionally taught in medical schools, which emphasize the diagnosis and treatment of disease.

It took Dr. W. Sterling Edwards, my coauthor, to resurrect my early interest in sharing with health professionals and other patient caregivers these remarkably effective interpersonal skills. Impressed with his innovative counseling of patients experiencing life-threatening diseases, I agreed to collaborate with him in writing a book that would use our combined experience to help both professionals and nonprofessionals improve the way they relate to patients.

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Introduction

W. Sterling Edwards, M.D.

As I finished my medical training in the early '50s, my interest developed in cardiovascular surgery. What an exciting time to be involved in the exploding field of surgery of the heart and blood vessels. I was fortunate to be a part of the early development of artificial arteries of cloth and the correction of birth defects in the hearts of children. I thoroughly enjoyed teaching medical students and surgical residents, and treating the physical aspects of patients' illnesses. But I realize now that I didn't do a very good job of relating to patients whose conditions were beyond my technical skills to cure. I didn't know what to say, my visits were short, my conversations were superficial.

When our children left home, my wife went back to college, got a master's degree in guidance and counseling, and started a counseling practice. In the early 1970s she registered for a 17-day workshop in psychotherapy, and I decided to go along. There I met and was assigned to a small group under Carl Rogers, a pioneer in humanistic psychology. I was impressed by his emphasis on the client-centered approach to treatment of emotional problems, where the patient participated actively in decisions about her or his treatment. At about this time I was appointed chairman of the Surgery Department at the University of New Mexico School of Medicine and director of its surgical residents' training program. As a result of my exposure to Rogerian principles, I decided to see if it was possible to develop a humanistic surgical residency program in contrast to the "Marine

boot camp" process of most programs. We developed a "resident-centered approach" where residents participated actively in decisions about their own learning. It worked. The morale was terrific, not only on the part of the residents but on the part of the faculty as well. Applications for the program multiplied. The humanistic aspect of the program became known all over the United States.

In 1987, I retired from surgery and from my teaching responsibilities at the university. In searching for a productive retirement career, I found myself attracted to psychology and the study of the emotional side of illness. I attended several courses in health psychology and some weekend psychology workshops. A number of nonmedical friends in recent years had developed life-threatening illnesses: cancer, heart disease, neurological problems. I began to ask these individuals if there was anything missing in their relationships with their professional and nonprofessional caregivers. A frequent answer was that caregivers of all kinds—doctors, nurses, family, friends—wanted to give information or advice, and very few wanted to listen to their feelings of fear, uncertainty, depression. That prompted me to explore the literature on listening.

This led to my discovery of the three best-selling books by Thomas Gordon, Ph.D., who had successfully taught hundreds of thousands of people a skill he called Active Listening. The three books on parent, teacher, and leader effectiveness training described how Active Listening and other communication skills could help individuals talk about their problems and express their feelings—often delving deeper and deeper into their own problems and often discovering solutions that were much better than others could ever advise. I decided to see if I could develop a "listening" practice for individuals with progressive or life-threatening illnesses. I also started a men's support group, a retired physicians' group, and a cancer patient support group.

In my individual counseling, I visit patients on referral, at their homes, at the hospital, or at the hospice unit. My objective is to encourage them to talk about their feelings about their illness or their relationships. I simply act as a listener, not judging or giving advice. I do this on a voluntary basis, since I want my relationship to be that of a friend rather than that of a professional. I make no diagnoses, give no second opinions, write no prescriptions. This experience has been tremendously fulfilling for me. I do not follow every patient until he or she dies. If I do not feel anticipation before a visit, fulfillment after the visit, and some connection during the visit, I am not getting any healing, and neither is the patient, so we break off by mutual consent.

After four years' experience I was encouraged by participants in several of these groups to write down my learnings in a small book. Since I had learned so much from the books of Thomas Gordon, I wrote to him and asked if he thought there was a need for a book to help caregivers become more effective and, if so, whether he would be interested in helping write one. I received an enthusiastic positive reply to both questions. So we set out to work together.

In working with Dr. Gordon, I learned there is a lot more to effective caregiving than just listening to patients. Active Listening does help when the patient has a problem, but what can be done to help when the patient is creating a disturbing problem for the caregiver? When is Active Listening inappropriate? What should a caregiver do if there is conflict and both have a problem? I learned that confrontive "I-Messages" and a six-step conflict resolution method, as taught in Tom's Effectiveness Training books and workshops, can be applied to the caregiver/patient relationship with great improvement in the quality of that relationship.

My own skills as a caregiver have greatly improved since my days as a surgeon. In this book Tom Gordon and I share our experiences with the reader.

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Chapter 1

Dissatisfaction with Doctor-Patient Relationships

> The doctor-patient relationship can be restored. But it will take commitment by people on both ends of the stethoscope.
>
> —C. Everett Koop, M.D., *Koop*

Even with the incredible scientific and technological advances available to health professionals, communication still is seen as the core clinical procedure for diagnosing, treating, and caring for patients. Furthermore, patients' satisfaction with the way they are treated by health professionals is strongly influenced by the quality of the communication that occurs between them.

Literally hundreds of research studies have confirmed what most patients have actually experienced firsthand—that how they are talked to by health professionals and how well they feel understood by them determines the degree of their satisfaction with those relationships. And, most important, if patients are dissatisfied with those relationships, studies show that it can seriously reduce their compliance with (or adherence to) their treatment regimen, it can make them have serious doubts about the competence of their physician, it can negatively affect how long it takes to get well, and it can increase the frequency of patient malpractice suits.

Undoubtedly, health professionals sincerely want to develop and maintain good relationships with patients. However, like most members of other professions—attorneys, engineers, executives, dentists, teachers, clergy, architects, accountants, for example—health professionals have seldom