How to win over patients and influence registrars

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How to Win Friends & Influence People

DALE CARNEGIE
Seminar Outcomes

• (Even) Greater patient satisfaction and cooperation

• Greater inpatient registrar satisfaction and cooperation

• Less conflict and less time wasted

• Better care for the patient

• More effective and more efficient health system
How will this be achieved?

• Quick review of what “satisfies” patients

• Discuss behavioural techniques aimed at both patients and inpatient registrars

• Use examples and quotes

• Throw in your two cents worth
Disclaimers

• Evidence in the area of influencing doctors is limited.

• There is a lot to cover in a single hour
My background to this topic

- Work in the ED
- Have multiple doctor friends who receive referrals from ED
- Have taken referrals

- Medical politics
- Medical indemnity role

- Jobs before starting medical school
Patient satisfaction - Health services overall

- the most important factor was 'humaneness'
  - ranked highest in 86% of studies
  - rarely, if ever, measured by KPIs

Emergency Medicine Manual, Dunn et al
Patient satisfaction - ED

- **Acceptable waiting times**
  - this relates to time to intervention rather than time seen by a doctor e.g. prompt symptomatic treatment
  - delays after being seen are usually better tolerated
  - long waiting time is the single most important predictor of patient dissatisfaction for low acuity presentations
Patient satisfaction - ED

- Staff attributes
  - humanistic qualities in staff including attire
  - empathy and attitude e.g. perception of how caring staff are
- Perceived technical competence of staff
- Pain management
- Information provided e.g. frequent updates
- Verbal and written communication
- Explanation of triage
- Other factors e.g. privacy, cleanliness, safety, noise
Complaints

- **Treatment complaints**
  - accounts for 33% ED complaints
- **Communication complaints**
  - around 30% of complaints
- **Access complaints**
  - present in about 25% of complaints
- **Complaints about rights**
  - about 2.5% of complaints
- **Administration complaints**
  - about 5% of complaints
- Environmental complaints
- Cost complaints
Winning over patients
Books get judged by their covers

- First impressions count
- You are a doctor = you are a professional
  - Patients can’t necessarily judge your medical knowledge
  - They can and do judge your appearance
    • Clothing – is denim OK?
    • Personal grooming
Mind your Manners

- Introducing and identifying yourself
  - Should you shake hands?

- Acknowledge and identify other people in the room – early

- Acknowledge (vs apologise) issues e.g. waiting time
“No-one cares what you think until they think that you care”

- Showing compassion and empathy (vs being completely impartial)
  - “That must have frustrated you”
  - “I imagine that caused you some discomfort”

- Identifying the patient concerns (may be different to yours!)
  - “So am I correct that you have come to hospital:
    - to get (insert issue[s]) resolved”
    - because you are worried about the possibility of (insert issue[s])”
Managing Expectations

- Every patient (and their support crew) comes to the ED with expectations about their care
- Expectations include
  - Timeliness – of being seen by doctor, of tests being done or coming back, of getting a bed
  - Diagnostic and Treatment methods – e.g. CT scans, intravenous vs oral therapy, specialist review
  - To admit or not admit – look for the packed bag(s)
Managing Expectations cont.

• Identify expectations early
  ▫ and then manage them just as early if possible
    • “That particular issue isn’t one we are best equipped to deal with in the ED – your GP is the best person to manage that.”

• Give patients an idea of the plan and estimation of timelines
  ▫ with suitable disclaimers about their accuracy
  ▫ And update them.
Managing Expectations cont.

• Let them know why you aren’t using the most aggressive therapy or calling in the specialty doctors
  ▫ “Antibiotics, like every medication, comes with potential adverse effects”
  ▫ “X-ray/CT comes with a small dose of radiation”

• Explain whether admission is required – choose your words wisely
Word Choice

• Need vs benefit
  ▫ “You don’t need to be in hospital” vs “I don’t think you would benefit from coming in to hospital”

• Painful vs comfortable
  ▫ Q:“Will this hurt?”
  ▫ A:“It won’t be completely comfortable.”

• The 2\textsuperscript{nd} most negative word in the English language is...
  ▫ “But” closely followed by “however” – both words negate what was said immediately preceding this word – use very carefully!
Honesty is the best policy

Diagnostic dilemmas

• Q: Is it OK to say “I can’t say for sure what is causing your symptoms”?

• Q: What if you follow this with: “But I am very confident that it is not something life-threatening or which needs urgent attention”

Mistakes

• E.g. with bloods – not signing group or hold - “Why are you taking more blood doctor?”
Encourage reviews and embrace uncertainty

• Let people know it is OK to come back if their symptoms deteriorate or just don’t go away.

• “The test of time”
  ▫ Could this be a benefit of spending time in the waiting room or in a cubicle waiting to be seen?

• “Trial of discharge”
Body language

• Tired – yawning, blinking, rubbing eyes
  • “I am tired and hence not able to provide best quality care to you – my retention of information and decision making abilities are sub-optimal”
  • “Your problem bores me.”

• Crossing arms vs open posture
The Definitive Book of Body Language

The hidden meaning behind people's gestures and expressions

Allan and Barbara Pease

The international bestseller!

Authors of Why Men Don't Listen and Women Can't Read Maps

A revised and expanded edition of Signs
Physical manoeuvres

• Sitting down =
  ▫ perception of wanting to hear the patient and not being rushed

• Importance of physical contact
  ▫ “The doctor didn’t even examine me!”
  ▫ Laying of hands
Your best medicolegal defence

Malpractice suits drop when doctors admit mistakes, apologize

By Jennifer Goodwin, HealthDay
The Illusion of Choice

• “locus of control”

• Patients often have relatively little control or choice in the ED

• Why not give them some?
  ▫ “Which arm would you like this IV line in, the left or the right?”
  ▫ “Which sedative would you like?”
Real choice

- Shared Decision Making
Shared decision making involves the integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to achieve appropriate health care decisions.

It involves clinicians and patients making decisions about the patient's management together.

In partnership with their clinician, patients are encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.

Shared decision making is of increasing interest to policy makers and international researchers. Current research indicates that:

- patients are less informed and involved in making decisions about their health care than they would like to be
- shared decision making can improve satisfaction with care and leads to better quality decisions
- patients using evidence-based decision aids have improved knowledge of the options, more accurate expectations of possible benefits and harms, and feel that they had greater participation in decision making than people receiving usual care
- better-informed patients make different, often more conservative, less costly choices about treatment, because, it is thought, that information provides a realistic appreciation of likely benefits and risks of treatment and enables decisions about the potential outcomes in a more considered way.
Special scenarios

- Patients brought in by police
  - Speak to the patient first
  - “Why do you think the police brought you here?”
  - OR “Why do you think your family member/partner/friend called the police/ambulance?”

- Patients with limited communication
  - Speak to family, even if it means calling them.
Influencing Registrars
Evidence

• Literature search
  ▫ Minimal number of relevant results
  ▫ Many related to white coats
  ▫ Other results were qualitative
Christmas 2009: Professional Matters
Selling patients

Peter Nugus, research fellow1, Jackie Bridges, senior research fellow2, Jeffrey Braithwaite, professor and director3

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The way hospital departments "sell" patients to each other has been parodied but seldom studied. Peter Nugus, Jackie Bridges, and Jeffrey Braithwaite explore the rules of the game.

"Since...gomers [Get Out of My Emergency Room] don't die...the term [turf] had to find other ways to turf them...The problem with the turf was that the patient might bounce, i.e. get turfed back...The secret of the professional turf that did not bounce, said the Fatman [supervising Resident], was the buff..."Because you gotta always remember: you're not the only one trying to turf. Every team and resident in the House of God is lying awake at night thinking how to buff and turf these gomers somewhere else."
Successful hospitalization of patients with no discernible pathology

Grant Innes, MD

"Take your work seriously — not yourself."

Introduction

Patients frequently present to the emergency department (ED) with complaints of chronic pain, dizziness, neurasthenia, cognitive deterioration, or neuromuscular dysfunction. Generally, they have already undergone extensive and fruitless investigation. Their clinical exam is invariably unrevealing, and even the most aggressive testing strategies turn up nothing. In most cases, the emergency physician’s only viable option is hospitalization, but without a clear diagnosis, inpatient consultants become testy, typically spouting irritating clichés like, “be a wall.”

Emergency physicians who admit patients with no discernible illness are often viewed as wimps or losers, and the admissions themselves as “dumps.” Because of the lack of a useful diagnostic test, the patients in question are labelled with derogatory descriptors like dwindles, failure to thrive, weak and dizzy all over, malignant fibromyalgia, unstable chronic fatigue syndrome, supratentorial pansynaptopenia, or gomer.

Recently, however, NIH (Northern Institute of Hypochondriasis) researchers have discovered that these seemingly diverse syndromes are, in fact, variants of a single pathophysiological entity, designated PWDP (patient without discernible pathology). The discovery of PWDP diagnostic criteria is a significant advance ($p = 0.02$); however, this entity remains a huge source of conflict for emergency physicians (EP). On a daily basis, EPs are caught between PWDP victims who require (or believe they require) admission, and inpatient consultants who cling to the outdated belief that hospital beds should be reserved for patients with treatable problems.

Most experienced emergency physicians have developed strategies for hospitalizing patients with no discernible illness. Such strategies are critical, but they are not described in the EM literature and they are poorly represented in EM residency teaching curricula. The objective of this article is to illustrate a common PWDP presentation and to describe effective dispositional strategies for EPs.

Case report

A debilitated middle-aged male was transported to the ED by paramedics after he was found creating a disturbance in a dumpster. On arrival, he was well known to the department. The attending emergency physician rapidly established that Phil’s presentation was consistent with alcohol intoxication, drug overdose, head trauma, metabolic derangement, sepsis, intracranial hemorrhage, personality disorder, multi-organ failure or hepatic encephalopathy. Road-testing revealed that Phil could not stand or walk. His old chart documented 79 identical episodes dating back 3 decades. On each occasion he required 7 to 10 days in hospital and, on each occasion, the discharge diagnosis was “weakness secondary to chronic alcoholism.” Phil had never been successfully discharged from the ED.

Using our PWDP Admission Algorithm (Fig. 1), the ED physician determined that the only viable course of action was to admit Phil to inpatient service. It was clear, however, that no consultant would be receptive — especially after viewing the old chart — and that it would take a wily emergency physician to succeed.

The ED admission team leaped into action, resuscitating Phil according to evidence-based PWDP guidelines. The ED nurse administered 10 mg of haloperidol for motor and profanity control, then 2 orderlies stripped Phil, burned his clothing, hosed him off, and...
Why influence registrars?

• You are the patient’s advocate
  ▫ They rely on you to ensure they receive the necessary review and treatment
Why is influencing difficult?

• You are a disadvantaged advocate
  ▫ Initial communication about patient with registrar normally always over phone – no visual cues=aids
  ▫ You know less (although not always) about that particular area – “Jack of all Trades, Master of One”
  ▫ You don’t control their beds or time
Wearing the inpatient registrar’s shoes

- Busy (usually but not always)
- Your call means work for them – and they aren’t paid per patient!
- May have had bad experiences previously with ED referrals
Asking for the consult
**ISBAR**

Clinical conversations should be clear, focussed and the information relevant.

Poor communication risks patient safety and contributes to adverse outcomes.

**I — Introduction**

“I am.................. (name and role)”

“I am calling from ....................”

“I am calling because..................”

**S — Situation**

“I have a patient (age and gender) who is

a) stable but I have concerns

b) unstable with rapid/slow deterioration”

“The presenting symptoms are............”

**B — Background**

“This is on a background of............”

(give pertinent information which may include:

Date of admission/ presenting symptoms/ medications/

recent vital signs/test results/status changes)

**A — Assessment**

“On the basis of the above:

□ The patients’ condition is ...........

□ And they are at risk of ...........

□ And in need of .............”

**R — Recommendation**

Be clear about what you are requesting.

E.g. “This patient needs transfer to/review ...........

Under the care of.....

In the following timeframe .............”
Common courtesy

• Check their identity AND if they are on call
  ▫ “Are you the [insert specialty] registrar on call?”

• Apologise for disturbing them
  ▫ even if you don’t really mean it because they are paid to be on call. “I am sorry to disturb you on this [insert time, and day of the week if it is a weekend]

• Identify yourself – including your full name and your seniority
  ▫ “I am a doctor from the ED” – NO
  ▫ “I am Tom Harry, one of the RMOs in the ED” – YES
Common courtesy cont.

• Identify their name if this hasn’t happened already
  ▫ For documentation AND to use later when you meet them.

• Ask if you can discuss a patient with them
  ▫ They can’t really say no if they are on call but they already feel they are dealing with someone considerate of their needs. Consider enquiring into their welfare - “Has it been busy on call?”

• Be polite – “kill them with kindness”
Frontload the referral

• Identify them and then you – then get straight to the core reason for calling AND the urgency.
  ▫ “I was hoping you could come down to see this patient in the ED reasonably quickly” OR “I don’t think you need to see them now but I think they would benefit from follow up in your outpatient clinic”
  ▫ “I am calling for phone advice only”
  ▫ “I was hoping to get your opinion on this difficult case”
Frontload the referral

• Tell them what you think is going on.
  ▫ “I think that this patient probably has condition [X] but condition [Y] needs excluding before we can have them seen by specialty [Z]”
• If you have involved a senior doctor – then say so.
• Tailor the “pitch” to the “customer”
  ▫ Surgeon vs Physician vs Mental Health Worker
When you’re not getting anywhere

- Clarify and overcome objections
- Start soft then harden up
When you’re not getting anywhere
Soft techniques

• Flattery will get you many places
  ▫ “[insert Plastic Surgery Registrar’s name], I could
definitely close the wound on this patient’s face but it
isn’t going to be as good a cosmetic result if you were
to do it.”

• Invoking the principle of what is best for the patient
  ▫ “This is a relatively young patient who is in an
occupation where a disfiguring facial scar is going to
be an impediment. I think we should aim for the best
possible cosmetic outcome which would involve
someone with plastic surgery expertise undertaking
the closure.”
When you’re not getting anywhere
Hard techniques

• Invoke family
  ▫ “If this was your family member would you be happy with this decision?”

• Invoke authority – go up the chain of command
  ▫ Your consultant
  ▫ Their consultant

• Asking for their name
  ▫ Informing them that your request for their assistance and their subsequent refusal has been documented in the notes and will be followed up within the ED.
The Squirrel Grip - Less ethical manoeuvres

• “Trading down” – knowingly asking for more than you actually think is needed and allowing to be bargained down e.g. Requesting 2 CT scans from radiologist, one of which is semi-urgent and one that is not urgent and settling for the semi-urgent scan.

• Dishonesty – lying vs omission e.g. omitting key details like the fact that patient is demented and with multiple co-morbidities and hence not likely to be an operative candidate
The Referral Piggy Bank/Credit Rating
Cliff Reid - "Making things Happen"

- Science of human influence
- How you appear
  - Be nice
  - Be authoritative
  - Ask for help
  - Use the group
- Push the right buttons "we would like your help on"
- Craft your language embed a fact, a presupposition, giving them the illusion of choice,
- Hypnotists technique "you allow yourself to note that your eyes are getting sleepy".
Teaching Medical Students and Residents How to Communicate with Consultants

Episode Eleven
February 2010

In this episode I interview Dr. Chad Kessler about the best way to communicate with consultants in the emergency department. Dr. Leslie Oyama from UCSD makes a special guest appearance as the "uncooperative consultant." This fantastic episode is a great resource for those of us who teach medical students and residents how to deal with consultants on the phone. You definitely don't want to miss this one folks!