THOUGHT **PAPER**

Therapeutic Relationships

How Physicians can Rediscover the Joy of Practice while Improving Quality and Producing Safer Outcomes

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From my first glimpse of her sitting in the waiting room, I knew she was going to pose a major challenge. Her snow white hair, tied back tightly, drew her face into what seemed like a permanent scowl. She fidgeted with a long sheet of paper I assumed to be her medication list as I reflected on how I'd come to know her story. The Emergency Department physician who had seen her the previous evening called to give me a preview of her many problems, along with her negativity to life in general and physicians in particular. With no small dose of apprehension, I wondered how I might best approach her.

As a Family Practice physician with considerable experience working with what we all at some point openly call "difficult patients," I assumed from what I'd seen and heard to this point that she would test the limits of my patience and probably my compassion as well. I took a deep breath, knocked on the exam room door, and walked in to see her in the very same pose I'd observed earlier. Without making eye contact she snarled, "You're late!" I pulled a chair up directly across from her, extended my right hand, smiled and said, "So I am, Mrs. Malony[1], and I sincerely apologize. My name is Dr. Dan Kopp and I'm happy to meet you. Dr. Rutledge called me last evening after seeing you in the Emergency Room. He wanted me to know exactly what he found during his evaluation so I might know where to begin this morning." She replied with the same tone as her greeting, "That doctor doesn't know crap from Shinola® and I doubt you do either. You're all the same."

So began my relationship with Rose Malony, an 82-year-old widow with multiple significant medical problems, along with a general tendency to make things up whenever she felt the need to be heard. She wasn't all that unique as it turned out, in terms of what she really needed. Obviously she required close monitoring of her significant hypertension, diabetes, emphysema, and heart disease, but more than anything, she needed to be taken seriously and regarded as a human being.

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I'd learned that lesson time and again over my years of working with patients and their families. In the end, it's really what we all want; to be taken seriously and regarded as human beings. On a subsequent visit with Rose, I learned she'd lost her husband in World War II, leaving her to raise four children on her own with the youngest dying in a hospital from complications of a medical error. Clearly the bitterness I encountered didn't begin with either Dr. Rutledge or me. It had evolved over many years of feeling marginalized by healthcare workers as just another ungrateful old woman with a handful of self-inflicted diseases. I learned she'd been estranged from her surviving children and their families for a variety of reasons, leaving her essentially isolated, without friends or family to care about her. She was lonely and in pain—some physical, but most emotional—and needed everyone she encountered to feel it, too.

1. Patient name has been changed.

As physicians we have the privilege and tremendous opportunity to meet people at their most vulnerable core and help them with our care and caring. Many patients begin and end multiple relationships with physicians and nurses while our assumptions about one another remain completely unexplored. Rose had a significant backstory that placed her in a totally different light than the one with which she always seemed to present.

If we avoid the strong tendency to diagnose too quickly and spend some time wondering what else could be going on, following the patient's story, and holding the patient in a dignified position as a fellow human being, the backstories almost always emerge.[2] It's the reason many of us recall patients who initially made the hair stand up on the back of our necks whenever they presented, and later became our favorites.

I had the privilege of knowing Rose for three more years, during which time we became good friends. On more than one occasion, she expressed to me how my listening had given her the courage to look at life differently. By the grace of God, she was finally able to re-connect with her children, and at our last visit, she showed me pictures of her newest great-granddaughter. Tears streamed down both our faces that day as we gazed at the beautiful child. It was the last day I saw her alive.

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The relationship I was able to create and sustain with this particular patient exceeded the best-case expectations I anticipated upon our first encounter. Initially there was no way to know how our relationship would evolve. She could just as easily have rejected my overtures and remained angry, disengaged, and bitter to the end. I believe every provider has had those experiences too, the ones that truly test our professional mettle. In those situations we're challenged to hold onto our principles in the face of adversity and rejection, remaining true to the therapeutic role. It's the most critical time to simply be present, open, and attuned to the person in front of us, regardless of the apparent disconnect.

Our nursing colleagues emphasize throughout their literature the privilege of caring for vulnerable human beings, and physicians obviously share in that experience as well. Patients presenting to healthcare facilities for help are worried, vulnerable, and often suffering. Depending on their capacity to cope, and their individual circumstances, they may present as angry, disengaged, and even bitter. When we can view such disharmony and discord as a common human response to illness or crisis, and as something we can be challenged by and actually love about our work, we grow as clinicians. If we can't, we lose sight of our work's purpose and risk burning out. Every clinician has had moments of looking past the person to seize the diagnosis—to expedite finding something that can be successfully treated, fixed, and crossed off the list. Personally I'm grateful those times have been few and far between, and that I've been able to remain

2. Koloroutis, M., & Trout, M. (2012). *See me as a person: Creating therapeutic relationships with patients and their families.* Minneapolis, MN: Creative Health Care Management.

engaged. It's allowed me to continue to experience the joy of practice. Physicians who routinely disengage from patients are at high risk for burnout and many actually become casualties in the increasing incidence of suicide. In the general population approximately 12 individuals per 100,000 take their own lives. Sadly, for physicians, the rate is three times that high, suggesting the tragic outcomes that can result from professional burnout and loss of purpose with one's work.[3]

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Although you can't force a positive physician-patient relationship, you can show up. You can remain eager to learn more about the person in front of you. You can engage in the mystery of their human condition and connect with them as a fellow human being.

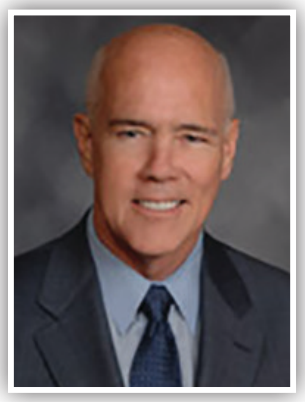
One of the many things I learned from my time with Rose is how important a backstory can be. What I didn't discover until years later is that it matters little whether I elicit it or not. When a patient is rude or angry, defensiveness or reactivity on my part is counterproductive. It's far more effective for the caregiver to accept that there are valid reasons behind the person's feelings and behavior. Although discovering a backstory can make it easier to empathize, it's still important to find empathy without necessarily knowing the root cause of the behavior. We can begin to see anger for what it represents: suffering. That recognition will then allow us to show genuine empathy for those expressing it. If someone we don't know lashes out or insults us, it makes no sense to take it personally. What *does* make sense is to train ourselves to recognize these behaviors as pain, frustration, or an expression of sorrow over feeling powerless and afraid. By doing so, we can remain present and continue to listen. We can give the person what they're actually seeking, whether they're conscious of it or not. They want someone to listen and be genuinely interested in them, to partner with them and find a solution to what they perceive as the problem. I believe such commitment to knowing patients as people can actually prevent burnout. This type of human connection can re-ignite passion for clinical work and restore purpose. More importantly, making such connections is something we can choose to do regardless of the environment in which we find ourselves. Authentically connecting with the person in front of us does not take additional time; it simply requires more focused use of the time we spend.

The success of my relationship with Rose was facilitated through partnership rather than the more traditional approach in which the physician is clearly the dominant force—the person in authority. For many years, health care providers have created relationships within this dominant-submissive model, and to continue this approach will undoubtedly cause more problems in today's era of enlightened patients striving to play a more significant role in their healthcare.

3. Miller, M., Ramsey Mcgowen, K., & Quillen, J. (2009) The painful truth: Physicians are not invincible. *Southern Medical Journal, 93*(10). http://www.medscape.com/viewarticle/410643_2

Relationships are forged in many ways and with many different results. As healthcare providers, we have an opportunity to create therapeutic relationships that are truly like no others. Although our intent is to provide care without expecting anything in return, when we connect with our patients as people, remaining authentically curious about who they are and what their struggles are, the return comes. It comes in the form of that warm feeling we get when we realize we're where we're supposed to be, and doing what we're supposed to be doing.

I'm certain that had Rose continued to meet multiple providers in random sequence, her life would have ended sooner; from gaps in compliance, medication error, or mistrust and not calling for help when she truly needed it. Physicians can increase their patients' safety and enrich their experiences with the healthcare system by engaging them in therapeutic relationships. The ability to create and sustain those relationships in large part demonstrates the leadership for which physicians were once known. With careful attention to the opportunities our craft allows, they can be again.



About the Author

Currently a Physician Consultant at Creative Health Care Management, **Dan Kopp, MD** was Chief Medical Officer at Faxton St. Luke's Healthcare in Utica, NY, from June 2008 through March 2013. It's his belief that most physicians still possess an internal flame fueled by the passion that originally brought them into health care, and that our challenge is to find unique ways to fan or reignite that flame. Dan is a graduate of the United States Military Academy at West Point and served as an Army officer for 28 years, 7 in field artillery, and 21 in the Medical Corps. He has over 32 years of clinical experience and has been a physician leader for 27 years. He's most passionate about developing and nurturing positive relationships among physicians and their clinical and administrative colleagues. His past assignments have included Vice President of Medical Affairs at Northeast Health in the capital district of New York; Chief Medical Officer at the University of Missouri Health Care System in Columbia, Missouri; and Deputy Commander, Clinical Services (military equivalent of Chief Medical Officer), at Fort Leonard Wood, Missouri. Questions or comments about this piece are welcome. Please direct them to: dkopp@chcm.com

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