SUMMARY

Excellent Patient and Family Experiences

Authentic Connection IS the Solution

Proceedings from an Intensive Session Presented at the
2013 International Relationship-Based Care Symposium
Huron, Ohio, September 11, 2013

CREATIVE
HEALTH CARE
MANAGEMENT

"One of the things we need to learn . . .is that very great change starts from very small conversations, held among people who care."

—Margaret Wheatley

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Introduction to the Content

Rebecca Smith

I'm Rebecca Smith, Creative Health Care Management's developmental editor and writing coach, and I have been asked to give you an overview of the four key practices that comprise the Therapeutic Relationship.

But first . . . I have been given the honor of helping this group to settle and focus.

It's no small task to shift into a slower gear. But as caregivers, I know that it's not a foreign concept to you at all. It's common, in fact, that even when the energy of the day or of your immediate surroundings is fast and chaotic, you have the ability to slow down and quietly attune to someone who may need an extra dose of therapeutic connection—perhaps to reassure someone that, if nothing else, *you* are present and interested.

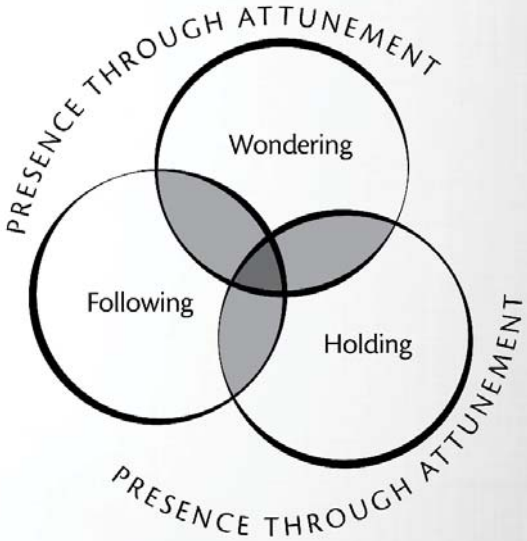
It's that sort of mindful attention that I'd like to invite you to bring to this session.

So . . . to that end, I'd like for us, in a moment, to take three deep breaths together. In the simple act of breathing deeply, you as an individual will become more mindful, more attentive. And in the exquisite act of our breathing deeply together, we will become attuned to each other, and the circle will be created.

<<<group breathes three breaths together>>>

The facilitators of this morning's Intensive are Mary Koloroutis and Michael Trout, the authors of *See Me as a Person* and the creators of The *Therapeutic Relationship Workshop*.

Before I turn the floor over to them, I'm going to define four key terms related to the Therapeutic Relationship. Some of you will be meeting these terms for the first time and some of you will be well-acquainted with them, so my aim is to be concise rather than comprehensive. Throughout the course of today's discussion, I suspect that even those of you who are completely new to this material will leave with the ability to bring all four therapeutic practices to your patient and family interactions.



As you can see, the three therapeutic practices of wondering, following and holding are shown here within a container of what Mary and Michael call "presence through attunement."

Presence through **Attunement:**

In this work, to be present simply means to be attentive to someone without distraction.

Attunement means to "tune in" to others exactly where they are . . . to be aware of their *aff*ect, their cues (both spoken and unspoken), and of their circumstances. Attuning requires remembering that what might be routine for us in the care environment is extraordinary or even life altering for the person receiving care. Many of us find presence difficult—particularly when we are in environments in which distractions are the norm. What Mary and Michael have discovered is that the conscious practice of attunement—the conscious practice of tuning in to someone or even some*thing*—actually *creates* presence.

Presence is a tough concept for people, but attuning is a practice that makes it easier. Attuning is a thing you can DO which helps you to simply BE.

What might be routine for us in the care environment is extraordinary or even life altering for the person receiving care.

The first therapeutic practice is **Wondering.**

Wondering is a practice of discovery grounded in curiosity and genuine interest in the other.

The therapeutic practice of wondering prevents us from drawing conclusions too quickly, which, among other things, can cause us to disconnect with people prematurely. We may be tempted to chase a quick solution or move to the next task, and in doing so, we may miss important information about the person in our care.

The next therapeutic practice is **Following.**

In this work, following is the practice of focusing on what the patient is saying and allowing the patient's perspective to guide your care. It is the practice of listening to, respecting, and acting on what we learn from the patient and the family.

This practice is usually the hardest one to grasp, but you may be able to see it more clearly by looking for just a moment at what clinicians (and people in general) sometimes do *instead* of following.

When a patient expresses fear, for example, following is *not* saying, "You'll be fine; the doctor is on her way." Following is allowing the patient to have his emotions and perhaps asking for more information, squeezing a hand more tightly, or even just allowing the reality of what the patient is going through to register on your face. In order to follow, you have to be able to be with people in their distress, and respect, appreciate, and learn something *from their responses,* about who they are and what they're going through.

The final therapeutic practice is **Holding.**

Holding is devotion to patients and their families. Our sense of devotion causes us to protect them in every possible way, including how we speak about them and how we allow others to speak about them.

Holding is creating a safe haven for healing in which people feel accepted and held with dignity and respect.

Simply stated: **The three practices of wondering, following, and holding, when practiced within a container of presence through attunement, create therapeutic relationships.**

Mary Koloroutis and Michael Trout have given definition to what already happens in your best patient/family interactions. You already do all of these things when you're at your best. I think my favorite thing about all of this work is that the formula for creating therapeutic relationships comes directly from the work of looking at successful patient-clinician interactions and discovering what they're comprised of. It's the very definition of "good science" in action: 1) Study what works, 2) figure out why it works, 3) consciously practice the things that are shown to work.

The purpose of deconstructing these interactions and giving definition to the individual practices that comprise them is to take the mystery out of therapeutic relationships. The ability to connect authentically can no longer be seen as one of those things where you're either born with it or you're out of luck. Authentic connection can be learned, reflected upon, practiced, and mastered.

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Opening the Conversation

Mary Koloroutis

I am particularly grateful that this intensive follows Brené Brown's inspiring keynote this morning. She has created a powerful foundation for us to engage "wholeheartedly" in a conversation about the importance of authentic human connection to the health and wellbeing of our patients and their loved ones, and also to the wellbeing of all of us in health care. To be authentic means, among other things, to accept ourselves and each other as we are. Our capacity for authenticity is dependent on our ability to tolerate our own vulnerability while taking full responsibility and accountability for our relationships. Authenticity is a practice of self-acceptance, self-responsibility, and accountability. It is a mindful practice.

70% of CEOs identify the patient experience as being one of their top 3 priorities.

With this in mind, let's reflect for a moment on what has been happening in the area of improving the patient experience:

There has never been a time in our history with greater focus or energy on how patients are experiencing their care. In a recent Beryl Institute study, 70% of CEOs identified the patient experience as being one of their top 3 priorities for organizational excellence and success.

It is well understood that while expert clinical/medical care is extremely important, patients see expert clinical/medical care as a "given"—a minimum expectation when they put themselves into our hands. The way they are made to *feel* is what distinguishes one organization from another.

Significant energy and resources have been put into teaching health care workers the fundamentals of good customer service. This includes practices such as introducing themselves, letting patients know their role, informing people about what to expect, asking if there is anything more they can do for them before they leave, and following up when they say the will. These practices are all extremely important, but I would argue that they do not represent a big differentiator for patients and families; they're not something people would perceive as "extraordinary"! People expect civil behavior and good manners. Like clinical medical expertise being a "baseline"; hospitable and civil interactions are expected, and rightly so. They bring us up to only the minimum expectation of our relational competencies.

Despite all of these activities, the latest Beryl study shows that CEOs are less satisfied this year than last year with their progress in measures of patient satisfaction. Further, clinicians are feeling "metric and monitoring fatigue" as they are trying to move the bar and often end up frustrated at the results.

Hospitals and clinics are more responsive and more hospitable, but excellent patient care takes more.

What does it take?

An article on the front page of the online *New York Times* last week was entitled: ***Fertility Diary: Finding a Doctor Who 'Gets' Me,*** written by Amy Klein. She describes her frustration, after years of fertility treatments and a "parade of doctors," at not being able to find rapport with any of them. She says:

> *I know the only thing that should matter is having a baby, not the relationship, but when you are opening yourself up — literally and emotionally — to an ob/gyn on a weekly basis, shouldn't you be able to have a connection? To feel as if you're being heard?*

Genuine human connection begins when we remember that we are in this together.

Amy finally had a breakthrough with a physician who she described as "the first doctor who actually listens to me . . . ," and it was so extraordinary and hopeful for her, that she wrote her story for *The Times*. She felt seen. She felt respected. She felt his genuine interest in her. She felt like they were in it together, and from that, she took hope.

The work of cultivating authentic human connection is work that takes us beyond acceptable care to excellent care; it moves us beyond the baseline. It also directs our thinking from "getting" the patient and family to be satisfied by what we say—i.e. "key words at key times" that are intended to influence how people score our services—to how we are present and responsive to the person in our care.

People know the difference between being handled and being cared for.

Remember "Communication 101" in which we learned that over 90% of communication is conveyed through our body language and tone of voice—our words have less of an impact. I would propose that when we are ill and vulnerable that becomes even more true. We know that people need to feel seen, listened to, and to have the undivided attention of the caregiver in the moments we're with them. Genuine human connection begins when we remember that we are in this together. When we join with the patient, we are in a better position to achieve the very best results.

We're here today to talk about authentic connection—even when it means staying fully present and helping the other to bear the unbearable. We all seek to create environments in which the heart of this high-stakes work is understood and clinicians receive the support and resources to fulfill their responsibilities with dignity and integrity.

Authentic connection. It is not a random phenomenon. For health care clinicians it is grounded in personal awareness and in a field of knowledge that looks at patterns of human response to illness and crisis, what it means to suffer, and to need care, and what we need to learn every day from the people in our care.

The four therapeutic practices: presence through attunement, wondering, following, and holding offer a practical methodology for authentic connection. As Rebecca noted, these practices are lived every day in our best interactions. By putting language to them, by holding conversations about them, we can more consistently bring them forth in our relationships.

Authentic Connection. We've all experienced it, and we've all also experienced the lack of it. And it's through our conversations that we increase our understanding and gain greater courage and

momentum to bring it to life for every person every time.

We have created a forum today for us to hold a small conversation together about a very big and important matter. I am so glad you have chosen to join us, and I invite you to join the conversation wholeheartedly.

And now . . .I'd like to introduce Marcus Engel. He will tell you a bit of his own story, but before he does, I want to share what knowing him has meant to Michael and me:

His commitment to advocating for excellent patient care has been an inspiration to us. He has turned his own adversity into a benefit for others, and it is impossible to calculate the impact he's had through his books and lectures, on the experiences of patients and families throughout the world.

Technical competence isn't optional; and neither is kindness or genuine caring.

In the beautiful Preface that Marcus wrote for our book *See Me as a Person,* he wrote something that we lift up in our teaching:

> *"People ask me sometimes whether I'd rather have a super-competent caregiver or a kind and caring one. In truth, I always choose competence, but I'm also always irritated by the question. It makes no sense to me that this is a choice that a patient should ever be forced to make. Technical competence isn't optional; and neither is kindness or genuine caring."*

He is here today to represent the perspective of the patient and also as a health care colleague. Marcus recently completed his Masters degree in Narrative Medicine through Columbia University in New York. He is always an inspiration—and he is always a delight . . .Please welcome Marcus Engel.

Why It Matters

Marcus Engel

Good morning, I also have to introduce my partner in crime; this is Garrett. Garrett has been with me for almost 3 years now. Garrett is my seeing eye dog, just in case you all have not picked up on the fact that there's a dog in a harness and a guy in shades potentially bumping into things. I'll give you a real quick story on Garrett. Just six months after I got Garrett, it was nurse's week, and I was doing a program for six or seven hundred nurses at a big health care system in Miami, Florida. I'm up on the stage; the stage is about 18 inches off the ground, and I'm using the edge of the stage as my guide so I don't end up facing backwards or something. Garrett is laying there with his paws draped over the edge of the stage and his head draped over the edge, and about half way through my presentation, Garrett falls asleep. But Garrett doesn't just fall asleep; he falls off the stage. He wasn't hurt or anything, but I think it bruised his pride because he jumps back up and kind of looks around like, "Did anybody see that? . . . " [audience laughter]

I can't tell you how honored I was when Michael and Mary approached me about writing the Preface for *See Me as a Person.* I was a grad student at the time, completely in over my head with the Narrative Medicine program at Columbia University . . . . this was about a year and a half ago. But I love the concept of their book, and it so aligned with things that I already feel in my heart, so I had to make that happen. It was such a wonderful experience, and I'm so honored to have that relationship with Creative Health Care Management.

To give you a little idea of where I come from with the authentic relationship, I have to give you a little bit of background. When I was an 18 year old college freshman at Missouri State University, I came home for the weekend. I was in St. Louis with some friends, and we went to a Blues hockey game. On our way home from that hockey game, the car in which I was riding with a bunch of my friends, was struck broadside by a drunk driver. That crash not only took 100% of my sight instantaneously and permanently, but it also crushed literally every bone in my face. After three hundred plus hours of reconstructive facial surgery—it took two years out of my life, until I could finally accomplish my goals of getting back into college.

So my experience as a patient started that cold October night in the Emergency Room at Barnes Jewish Hospital in St. Louis. Luckily the crash was only about three miles away from that incredible trauma center. Thinking back to the first relationship I made in the hospital in that emergency room . . . well, there wasn't a lot of interaction. My head was swollen to the size of a basketball. I'd been trached in the field, I could hardly hear because the swelling through my ear canals was so huge, my left ear canal was cut clean in two, and with permanent blindness, moderate deafness, all the broken bones, all the pain, all the incredible amounts of narcotics . . . .

Through that first night, the comfort that I received came from a 20-year-old named Jennifer. Jennifer held my hand that entire night. Anytime she would see me stir, Jennifer would give my hand

a little squeeze and I would squeeze back, and Jennifer would say, "Marcus, my name is Jennifer, you're in the hospital, you were in a car accident." And then Jennifer said the two most compassionate words I think any human being can say to another. "Marcus, I'm here . . .I'm here."

That's what I needed. When my world had been turned completely upside down, when I didn't know what was going on, when I was in such pain, and when the narcotics were having such an effect on my brain, Jennifer gave me the bare bones information. And when I was in that state, what I needed more than anything was simply to know that another human being was present during my time of need.

Jennifer knew that in my most vulnerable moments, what I needed was to know that I was not alone.

Anybody want to take a guess what Jennifer's role was in the ER that night? The truth of the matter is that Jennifer and I were kind of like ships passing in the night, because for 20 years I had never known what Jennifer's role was. All I knew was that she was 20 at the time, that her name was Jennifer, and that she comforted me with those two words.

Flash forward to January, 2013, when I was invited to Barnes Jewish Hospital to give a keynote . . .kind of one of the crowning moments of my career, to go back and present for people at the very institution that saved my life. After one of my keynote presentations, my client came up front to the platform and said, "Marcus, we've got a surprise for you . . . . we found Jennifer." To be able to hold her hands for the first time in 20 years, and to thank her for being present with me that night, when all she could do was hold my hand and say, "I'm here,"—to be able to thank her for that was one of the most precious moments of my life. What I learned that day was that Jennifer had been a 20-year-old patient care tech.

We all know there's a hierarchy in health care, right? We admit this, correct? Where does a 20 year old *anything* rank on that level of hierarchy? Jennifer didn't have years of higher education; she didn't have all kinds of designations, she didn't have alphabet soup behind her name, but she knew that in my most vulnerable moment, what I needed more than anything was simply to know that I was not alone.

You know the best part of this story? My awesome wife got a two minutes heads up that I was going to be meeting Jennifer, whipped out her trusty iPhone, and caught it all on film. And if you want to see this, you can see it at www.imheremovement.org. Jennifer had no idea that her words had sparked the title of one of my books or that the "Jennifer story" is part of a presentation that hopefully has changed the practice of so many health care professionals.

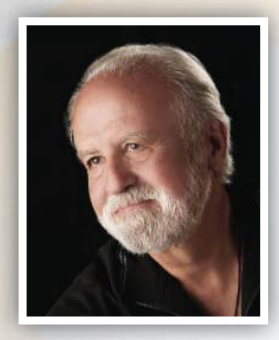
Not only did I get to be reintroduced to Jennifer that day, but I also got to honor my very favorite nurse from my recovery time. Her name was Barb.

Let me tell you just a little bit about the authentic interaction with Barb from minute one. It was after I'd gone through a 25 hour facial reconstruction. I was wheeled into the ICU where Barb was working that night, and Barb came to the side of my bed. I can't talk; I can only write out things on a pad of paper, and Barb says, "Hey, Marcus; my name is Barb. I'm going to be your nurse tonight, and do you prefer to be called Marcus or Marc?"

Now if I can draw the picture for you, I am black and blue from head to foot, my eyelids are sewn shut, my jaws are wired shut, I have a trache, I am a blind, mute, and disfigured patient. I am a hunk of meat with tubes running in and out of me everywhere, and Barb takes the time to simply ask me, "What do you want to be called?"

Was Barb seeing me as a patient, or was Barb seeing me as a person? [audience murmurs] Absolutely . . .a person. And then . . .I don't think I ever realized this until I heard Dr. Brown speak this morning, but then Barb got real vulnerable with me, and she said, "I'm going to be quite honest with you. I have never seen a patient who is hurt as badly as you are. But I just want you to know that you are in the best hospital, and we are going to take great care of you." That started off the authentic relationship between Barb and me. And I can tell you stories until I'm blue in the face about how that authentic relationship affected me, affected my family . . .but you can read all about in the Preface to *See Me as a Person.*

Bringing It to Life



Michael Trout

We're going to spend much of the morning deconstructing the ideas about The Therapeutic Relationship you've heard so far, finding out how they apply, thinking about why (surely) they must *not* apply, or why these ideas are absolutely unworkable in your system, or why they are a poor fit with your personality.

I want to begin with an acknowledgment: there's absolutely nothing about the three intricate concepts of wondering, following, and holding that is new. While it may sometimes feel so, there's nothing about them that's beyond the scope of any of us in this room.

My grandfather was a grumpy old fart. I understand he was a rotten father to my mother and my uncles. He was also extremely quiet when with me. But he would also go for long walks in the woods on his farm with me. The silence was only broken by his identifying a certain bird he just heard or his explaining to me why walnuts smelled that way and how if you rub one in your palm it will smell that certain way on your hand for the rest of the day. To this day, I still love to do that. There was nothing sweet or even loving (on the surface, to an outsider) about those interactions. It didn't take him extra time to engage with me in these ways. But my memory of these walks is strong and clear. The feeling of being with this big, quiet guy has stuck with me to this day. Why is that?

I think it has something to do with the fact that I felt treasured by that man. My being treasured probably had less to do with me, really, than with the fact that I, his firstborn grandson, came along just a few weeks after his own firstborn son was killed in the Philippines, at the end of World War II. Nonetheless, I felt valued by him. He saw me.

I want you to keep that picture in your mind when you think about the concepts we talk about today. It's really just an everyday story of a grumpy old man loving a baby—and the baby being changed forever, because of it.

One other idea I want to plant in your head just occurred to me this morning. [kneeling by a seated participant, taking her hand] When this fellow Jesus fell to his knees in front of members of his flock, there was little fanfare. He just stopped, dropped, and engaged, while gently caressing his disciple's feet, then tenderly washing and drying them. Perhaps he looked into the stunned eyes of his disciples while he carried out these quiet acts of care. Why did he do that? How did he know that it was important? How did he understand attunement?

That's what we do. We quietly surprise with our presence, and then with our unexpected acts of attunement and care. That's about the size of it: engaging with our patients in ways that allow them to feel utterly seen, as if nothing in the world exists in the moment except that patient and *you*.

That's The Therapeutic Relationship. And that's what we're all going to talk about this morning.

Members of the Panel

Representing the "Voice" of Nurse, Patient, Physician, Family Member, Leader/Researcher, and New Clinician

Each panel member was asked to reflect on this question: What is on your mind about authentic human connection in the patient experience?

Voice of the Nurse

Nancy Dole:

Health care has changed so greatly in the nearly 30 years that I have been practicing. We have made so many positive strides in the advancement of technology, and tasks and procedures are done so quickly and efficiently—especially when it comes to progress using electronics which now includes the entire medical record. I am amazed at the things we do today, how quickly patients are in and out for procedures that may have taken many more days years ago. Patients are sicker, but length of stay is shorter and turn-around time is quick.

Part of what's on my mind is that this fast-paced, often chaotic environment can create conflicting priorities in our care. Along with that reality, I also want to share some of the great things that are happening in my organization and my own practice—despite the pace and chaos—since we intentionally made attunement, wondering, following, and holding part of our culture.

We are urged to do more and produce more, and as nurses, we get sucked into the vortex of this process, often creating a disconnect with our patients: the very purpose of our work. This chaos leaves little time for reflection, connection, or feeling, often leaving the patient feeling like a number.

The introduction of Therapeutic Relationships to Covenant Health has re-sparked the passion I have always held for nursing and my main purpose for being in the role that I am in, which is *complete* care of the individual entrusted to me. It reinforces taking the time, even just 5 minutes, to connect with purpose and intention. The therapeutic relationship is really like no other relationship that we have with people as it's *meant* to be "one way"—it's for the patient. That said, as a caregiver, I get so much in return! I have come to realize how meaningful this connection is to the patient and their family members and the gratitude they have.

I now tend to pause and pretend that I am that person in the bed or the family member in the chair. What am I seeing, and how might I feel?

This practice of stopping and deliberately attuning to the patient, before we even interact, has given me some surprising gifts. What I have found is that when I attune to the uniqueness of the individual and remember to wonder, I learn more about not just the physical problem that brought them to the hospital, but how it is affecting them and their family. I have learned stories about difficulties facing other family members at the same time, or the stress of having a hospitalized child when their previous experience in the hospital was with loss of life. Somehow my having this added knowledge strengthens the bond in this relationship. Patients feel more secure in our knowing "the rest of the story."

"It's so evident that the nurses, therapists, and doctors all work as a team here . . . it's really all about my son."

When I use the practice of following, they appreciate that someone is truly with them on their journey. We ask patients to participate in setting goals, and ask, "What is the most important thing we can do for you today?" In pediatrics we are having the children participate the same way. As the nurse, my goal may be having them drink and retain a certain volume or to ambulate several times. But the child may have a totally different goal such as "I just want to go camping!" We write their goal on the white board in their room, and their physicians are attuned to looking at this when they round. As a team we consider what is most important to *that* child *this* day when planning their care. They participate in what is happening to them and are often more willing to be fully invested partners in their care.

I have seen the impact of bringing therapeutic relationships to our patients, and it is GOOD! They feel unique, they feel special, they feel held - and mostly, they feel cared for!

Patients and families at Covenant often write Stargrams [notes to recognize staff]. One example said "I felt like the nurses didn't just talk to me, they actually listened and understood what I was going through." When rounding recently, I had a mother tell me, "It's so evident that the nurses, therapists, and doctors all work as a team here. You can tell it's not about the money—it's really all about my son." That was the best compliment that we could have asked for!

I also see the impact and culture change that our work with Therapeutic Relationships is creating with the staff as more participate in the workshops and are excited to bring these ideas back to their departments and the patients in their care. During reflection sessions the nurses share stories of now focusing on attunement and wondering. They are discovering the back stories of individuals who, before learning about the Therapeutic Relationship, they may not have taken the time to get to know in more depth. People become open and vulnerable, and it allows the staff nurse to truly understand where they are coming from as they face their current health issues.

Nurses acknowledge that using techniques in Therapeutic Relationships to manage anger has also diffused difficult situations which they used to try to avoid. They have shared during reflection how they now recognize that the patient's anger was a symptom of fear or frustration and how by offering compassion and acknowledgement of their

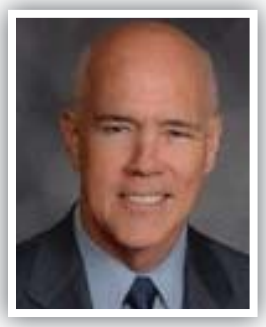
suffering it helped not only diffuse the tense situation, but allowed the patient to progress and heal.

Utilizing the concepts of Therapeutic Relationships makes me feel so good about delivering total care. Do we still have crazy chaotic days? Yes, absolutely! But remembering to make connections with intent, or recognize that no matter how busy or miserable my day may seem, the person in that bed didn't make the decision to get injured or be sick and go to the hospital! TR [The Therapeutic Relationships Workshop] has been the shot in the arm that I have needed after many years of care—to re-acquaint me with the true purpose of nursing—recognizing the needs of the total patient: biological- psycho-social and spiritual. People are not numbers to flip or DRGs to meet. I like to go home at the end of the day and feel proud of the care that I have provided. I *always* feel a sense of pride when an individual or their family member feels held in my care!

Bio: *Nancy is a proud member of the nursing profession who is dedicated to caring for children and their families in her home community of Saginaw, Michigan. She has been a member of the pediatric nursing staff for more than 29 years, providing technical and spiritual support to children and their families while sharing time as the nursing educator for the Pediatric Department.*

Since her first exposure to the tenets of Relationship-Based Care, Nancy has been passionate about sharing these concepts with others, both as a leader for integrating RBC into Covenant Healthcare and as a certified facilitator of The Therapeutic Relationship Workshop. *Her goal is to bring awareness of Therapeutic Relationships to the 4000+ employees of her organization. Nancy Dole can be reached at ndole@chs-mi.com.*

Voice of the Physician



Dan Kopp

Good morning. My name is Dan Kopp. I'm a Family Physician, and I work with CHCM as a physician consultant talking to medical staffs around the country about how we physicians might better engage in Relationship-Based Care and Therapeutic Relationships with our patients, their families, and our health care colleagues.

I've been a board-certified Family Physician for over 33 years, spending 25 of those in the full-service practice of Family Medicine, and for the last 10 years, as a senior physician leader. I've served as Vice President of Medical Affairs (Medical Director) in several community hospitals and as Chief Medical Officer of a major medical center and most recently a large health care system in upstate New York.

What's on my mind about Therapeutic Relationships is that we physicians have frequently relegated them to an assumed presence and no longer take the time to work at them. Quickly and efficiently diagnosing and treating presenting problems has become our primary goal, leaving the development of Therapeutic Relationships largely to chance. It's my belief these relationships cannot just happen naturally. They must be created with

forethought and attention to detail with each step along the journey.

I believe many of my physician colleagues have lost much of the joy in their medical practice due to a number of factors. Financial reimbursements are down due to health care reform changes, so many physicians are working longer hours for less salary. Tighter regulatory controls are taking a toll as well. Physicians are being asked to play a larger part in preparing for certification visits by state and national agencies, often seeing these requirements as superficially administrative, with their only reward being to keep their hospitals in "deemed status" by Medicare. Then there are the challenges of adapting to the rapidly increasing automation in medicine. Most have had to learn how to keep their records electronically, requiring them to fundamentally re-engineer the processes of their practice. Finally, they're seeing increased demand from ever-more sophisticated patients, often shopping for what they want—or think they need—among providers, based many times on information they've gleaned from the Internet.

With the increased pace these changes have brought about, physicians have less time to spend with patients, consult with colleagues, continue their education, and enjoy their families, bringing them ever-closer to "burnout."

Here's what I think many of my colleagues would say today if asked how they feel about their current situation in health care:

"I've lost much of the satisfaction I once felt with my career. I'm further behind in my work, and the tasks of personal life each day are making me increasingly anxious. How I miss the joys of practice I used to experience! To make matters worse, I no longer feel the respect of my patients and other health care staff as I once did. I'm beginning to wonder why I ever chose to become a doctor!"

I believe a major strategy in regaining much of the joy that's been lost, and once again experiencing the appreciation and respect of patients and health care colleagues is to re-engage in the most fundamental of all medical interventions: a return to authentic connection with patients. Developing and sustaining that special therapeutic relationship with them, re-deploying many of the relational practices we seem to have forgotten. Taking the time to truly listen to our patients as fellow human beings, wonder about them, follow them, and most importantly, hold them in a safe place, literally and figuratively, will in my view provide a pathway to re-charging our batteries as physicians and allowing us to once again experience the joys of practice.

True therapeutic connection can likely never be one-way. For it to be of value to the patient, it must be of value to the caregiver as well.

So what's on my mind about authentic connection and therapeutic relationships is that while our foundational theory defines them as unidirectional, with caregivers giving and expecting nothing in return, we can't deny that something of great value is most definitely received by the caregiver. True therapeutic connection can likely never be one-way. For it to be of value to the patient, it must be of value to the caregiver as well.

I look forward to our dialogue this morning.

Bio: *Dr. Dan Kopp is a 1969 graduate of the U.S. Military Academy at West Point, NY, and a 1980 graduate of the University of Alabama School of Medicine in Birmingham. He trained as a Family Physician at Madigan Army Medical Center in Tacoma, WA, from 1980-1983, and has been board certified in Family Practice since that time. He's served as the Chief Medical Officer at the University of Missouri Health Sciences Center and School of Medicine in Columbia, MO, Northeast Health in Albany, NY, and most recently at Faxton St. Luke's Healthcare in Utica, NY.*

A retired U.S. Army Colonel after 32 years of active duty, having done 25 years in full-service Family Medicine in multiple assignments around the world, Dan is excited to now be working as a Consultant for Creative Health Care Management. Dan Kopp can be reached at dkopp@chcm.com.

Voice of the Patient

Marcus Engel

I guess you already heard about what I'm typically thinking about authentic relationships, which is the idea of simply being present. We can't truly be in an authentic relationship with someone if our minds are wandering, if we are worried about what's going on at home, if we have that ache in our foot after standing up and taking care of patients for eight or ten hours without a break—those are all things that I feel detract from the ability to be in an authentic relationship.

I'm always talking to health care professionals about that simple act of presence. There are so many things that work against someone's desire to be present in the moment with a patient. And that's where I started to come up with this idea of, "How can I help the profession that saved my life?" I wanted to know how I could take my experiences and help those very people in that very profession responsible for the fact that I'm able to be here today and talk to you.

I think I mentioned earlier that I just received my graduate degree in a field called Narrative Medicine. If you have not heard of Narrative Medicine, you will. As we in the world of health care start moving toward compassion, toward that holistic way of taking care of patients, you're going to hear more and more about the integration of the humanities with health care. I found this incredibly exciting, because for me, a writer who also works in health care, I found out there's a Master's program out there specifically for me!

What I have learned, both anecdotally and academically, is that nurses are wearing too many hats at one time. I think we all can sit here and probably count off at least half a dozen, if not more, hats that we wear. The stats bear out that over 90% of nurses are female, and we all know that females run the world. That also means that nurses tend to be not only professionals in their field but also parents, partners, in relationship with siblings, potentially in that "sandwich generation" of taking care of aging parents, and then on top of all of that, you still have to pay the bills and get the groceries. That adds up to a lot of stress before one ever puts on their scrubs.

In my grad work, I created a seminar called Narrative Nursing. And again, this was all done to try to teach nurses to embrace their own stories—to see their stories as valuable and beneficial, not only to themselves, but also to other people. The aim was to use writing as a cathartic, therapeutic resource. These days I'm trying to help those professionals who saved my life by helping them save their own lives and sanity by learning to use their stories and value their stories as they go forth into their profession—to help that authentic relationship between caregiver and patient.

Bio: *Marcus Engel is a professional Speaker and Author who provides insights and strategies for excellent patient care. Marcus is a 2012 graduate of the Masters in Narrative Medicine program at Columbia University in New York City. His books are routinely utilized by major health care systems and universities across the country. Marcus is a leader in the field of the patient experience and the founder of the "I'm Here Movement." Marcus can be reached at Marcus@marcusengel.com.*

Voice of the Nurse Leader/Researcher

Kathleen Vidal

I'm Kathleen Vidal, and I'm representing the voice of the nurse researcher. I collaborate at all levels of the organization to identify and promote best practices related to the patient experience. Trending HCAHPS data as well as rounding with patients and staff help me identify opportunities for improvement. I am here today because of the research we have done to shed light on patients' perception of caring.

What is on my mind about authentic connection and the patient experience is this: Caring seems to have become a buzz word.

Everyone is jumping on the bandwagon with lots of slogans and classes to make your organization a caring organization in 30 days or less. They are often redefining caring as quicker response time, cleanliness, scripted phrases, etc. But this isn't what patients tell us caring is.

The Relationship-Based Care model adopted at UHCMC certainly provides opportunities to listen to patients. Admitting staff show curiosity into the patient's story and inquire about the patient's and family's most important concerns. Physicians and nurses pull chairs up to the bedside to hear what is on the patient's mind. A follow-up call is made to check on the patient once they return home, ensuring that our care extends beyond the brick walls of the hospital. Additionally, patients and families are invited back to share a meal with staff and share their story. Staff listen attentively as a patient shares a story where everything was good, but there is maybe one thing that didn't go so well. It is from this one thing that staff learn how to improve delivery of care.

Since Relationship-Based Care was implemented at my organization seven years ago, we have been conducting an extensive research study. This study involved written surveys of 222 nurses and of 376

patients. Our goal was to see how Relationship-Based Care affected the nurse and patient perception of caring and readiness for discharge. Our initial findings showed a strong correlation between the "sit down round"—where nurses and physicians sit at eye level with patients and talk about what is on the patient's mind—and nurses' perception of care and patients readiness for discharge. We used the Caring Assessment Tool (Duffy, Hoskins, Seifert, 2007) derived from Jean Watson's carative factors. Most of the patients reported feeling well cared for; the average score was 4.4 on a scale of 5.

However when Dr. Anthony, the lead investigator, did a more detailed analysis of the data, there was an emergent theme that I think has great bearing on this concept of authentic caring: Caring behaviors emerged to be those that allowed the patient to be the driver of their experience.

Caring behaviors emerged to be those that allowed patients to be the drivers of their experience.

In brief, the patient's overall experience of caring was influenced by nurses' ability to support patients involvement and ability to be the driver of their own interventions. In other words patients identified a high level of care when nurses had the ability to elicit patient inner strengths and resolve. I think the outcomes of this research tap into the true essence of caring. We certainly need to develop this further, but I am confident that additional findings will support the emerging finding that caring comes from authentic connections and support. In health care, we continually strive to engage patient and family participation in managing illness and adopting healthy behaviors. I think this research highlights the important role of nurses in making an authentic connection to help a patient identify their inner strengths and ability.

As nurses we need to hold on to the essence of caring: the authentic connection with the patient. Instead of giving nurses slogans and buzz words, we need defined methods of caring and connection. That is why I am so grateful for the work of Mary Koloroutis and Michael Trout and many others in the room. Their work creates clarity and a framework to teach and model authentic caring. The practices of wondering, following, and holding allow nurses to know and support patients as they maneuver through their health care challenges. In a recent video we made, one of the patients talked about staff members who really cared: "They are the ones who come in, we are talking, and before I know it, I forget my state of mind and get back to feeling my inner strength and we are talking and laughing."

We who work in health care directly, understand quite well what authentic connection creates for the patient and family. However, if we're going to make significant headway in making authentic connection the norm, more research is needed. We need this research to support models of health care delivery built on the framework of human connection. We need to have findings that can back up what we already know—that nursing leaders need to protect at all costs the time and processes necessary for nurses and patients to connect in an authentic manner as evidenced in attuning, wondering, following, and holding behaviors. Additionally we need to create an environment that allows our new nurses to see these behaviors and develop the skills necessary to be authentically present. As health care professionals, we need to share this knowledge and hold others accountable to model authentic connections. In doing this we will create a health care environment where the

patient truly is at the center and is the driver, fully participating as a unique individual in creating his or her experience.

Bio: *Kathleen is Director of Nursing Practice Development at University Hospital Case Medical Center. In this role, she supports the University Hospital System in education, implementation, outcome monitoring, and research of its interdisciplinary relationship based model of care. Kathleen can be reached at Kathleen.Vidal@UHhospitals.org.*

Voice of the Patient's Family

Marvelyne Engel

What's on my mind authentically? The very first thing was to make sure that I don't accidentally flash everybody with my skirt being a little short. [audience laughter] The second thing is that my husband stole the first two paragraphs of my prepared talk to you today. So we might have to go swimming later and discuss that, Darling. [audience laughter]

I was going to start out talking to you about wearing different hats. I've been a patient, I've been an emergency patient, I've been a chronic patient where you're seen all the time and the doctor's like, "Okay, you're calling again?" But what I'm here today to talk to you about is the ugly stepsister of all of that which is the thorn in most of your sides by reputation, and that is the family of the patient.

I can't tell you how many times I've heard, in working with health care organization, "The patients are okay, but my goodness, their family members drive me crazy!" Have you ever felt that way?—You don't have to raise your hands . . .

Unlike you, caregiving is not something I do professionally, but it is something I do every single day of my life. And just like you do it in a professional setting, you also do it in other settings every day of your life. You wear your nurse or physician uniform on the job, but you also have lots of experience being the unofficial health care provider for your family and probably a lot of your friends who call you and say, "This is turning purple . . . is that okay? . . . Will you look at this rash for me?"

Often the hardest time to be in the hospital is when you're not the patient, but instead you're the family of the patient. I have spent a lot of time in the hospital as the family of the patient and those walls are not very thick . . . especially the curtain ones. So I've heard a lot of negative interactions, and I can understand why health care providers feel often like the families are the biggest challenge. I've seen the way families can act and behave, and it would horrify me if I thought you think I'm going to treat you like a waitress or that I'm going to demand more ice chips and, "You'd better bring extra because my sister's coming too . . ." I wouldn't do that.

I will say that I HAVE been the crazy, frantic lady running down the hallway screaming, grabbing a doctor, literally yanking him into my husband's room saying, "You've got to look at this NOW." In

my defense, that was after sitting five hours in the ER, almost two hours in the exam room, not having a doctor in there, and even as a nonprofessional, I knew a 6-inch incision from a recent surgery that looked like a football was about to burst through it and had red streaks growing off of it by the moment, was not something that should be happening. It turned out to be a vanco resistant bacteria that had entered my husband, and I would run down the hall and be the crazy lady again in a moment, because I HAD to. I was in that position and I needed to. I hope it never happens again.

We all know that when you're taking care of a patient, you address them directly. You make eye contact with them; you communicate with them, don't talk ABOUT them to whoever is with them—in other words don't sit there with my husband and I when he is the person you're there to see and talk to ME and say, "Is he okay or can he do this?" Talk to the patient—we all know this, and I'm sure that those of you who are here are very, very good at that.

Take a moment and offer some insider advice: "The good coffee's on the 3rd floor . . . "

But here are some tips on how to get the family on your side and really help them:

One is if I'm accompanying my husband or my son or my mother, take a moment to also ask what my name is. Get the relationship. Those few seconds will make me feel included and will make me feel like we're a team. That way I'm not an anonymous person who you don't even realize is in the room.

Then watch to see how the patient—the person—responds to my being there. Do they look uncomfortable? You have to be the judge of that. Or do they look comfortable, and if they look comfortable, include me in the conversation. Understand that this is a good thing—that we're all on the same side. If they're happy to have me there, act like you're happy to have me there too.

Remember that in some cases, a family member is a much better medical historian and record keeper than the patient. It's especially true if the patient is elderly or a young child or maybe just a really shy person or they're seriously sick. Sometimes your best information can come from the family; we can be a really good ally. Now none of that means that you forget rule number one, that you talk directly to the person, or that we're all on the same side and we all want the patient to heal.

It's also valuable to remember that I, as the family member, need to understand the process and the procedure that is scheduled, because many times, as soon as the physician or nurse leaves the room, my loved one looks at me and goes, "Now, what's going to happen? . . . What does that mean? . . . How long will I be here? . . . Well, did she know that I had a surgery last week? . . . Do they know that I've already done that?" And I'm supposed to have these answers. So when you include me in the conversation, and when I understand, I can help make sure that my family member understands better. My ability to confidently pass on that knowledge, comforts everyone.

I know that a family's behavior and outrageous demands, sometimes acting like they're the only ones on the floor who matter, can drive you a bit nuts. But I also know that if you take a bit of time just to relate to the family and assure the family that you're working TOGETHER, with them, not against them, that moment of insider advice when you go, "The good coffee's on the 3rd floor . . . ,"

makes such a difference in how they're going to respond to you and receive help from you.

Remember that while I'm here with the patient, and they're being told, "You need to rest; it helps you heal," I'm the one who is lucky to catch a cat nap in those awful vinyl chairs with a crick in my neck. I'm the one worried about who's going to pick the kids up from school. I'm the one calling my boss to tell him I'm going to be late. I'm also juggling 15 things, and I'm not being encouraged to lay back and rest, but I should be.

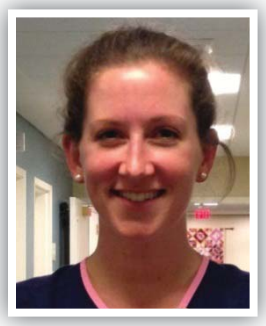
What I want you to know about me as the family member of the patient is that I am exhausted. I'm overwhelmed, I'm unable to break down because too many people are depending on me to hold it together. And worst of all, my loved one hurts, and whether it's reality or not, I'm afraid they might be dying. I want to know, and I need to know that you, the expert, are giving your best help and attention and presence to me and my patient.

Excellent medical care is my primary concern—there isn't a question of that. But a huge component to what makes medical care excellent is the human side. Communicating the compassionate relationship between the caregiver, the patient, and the patient's family—the value of this just cannot be overstated.

Take really great care of my son, my mother, my husband . . . but let me know you're nearby, building a safe relationship with me, where I get a moment to ask a question. Give me a bit of assurance. Offer me a kind word. Pass along whatever information you can. I promise I'll be a much better family member, and your patient will recover a lot faster.

Bio: *Marvelyne is a writer and speaker who helps heal invisible wounds. After two decades of serving in counseling ministry, she is now pursuing an M.S. in counseling with a focus on helping those dealing with traumatic events to find their own authentic path to healing. Marvelyne is a parent of three, all of whom were patients at more than one point; she is also a relative of several people living with chronic illness. She is the wearer of many hats: wife, mom, daughter, sister, friend, adventurer, lover of shoes, and collector of stories. Learn more at her blog www.aLittleMisadventure.com.*

Voice of a New Clinician



Hannah Somers

I have been a nurse for a year and a half. As a newer nurse, I have a lot on my mind about how I can connect with my patients and make their experiences better. There is a lot I want to learn.

I am part of this panel because of my desire to learn and contribute to discussions about the importance and impact of therapeutic relationships. While I now have many ideas on my mind about building authentic connections and improving patient experiences, I just began my nursing journey a short time ago, not knowing much about what those topics meant.

Before I began nursing school, I felt drawn to nursing because of what I imagined it could be like to be the kind of nurse I dreamed of becoming. If that sounds like a very confusing thought, it was! I didn't even know what I meant exactly, but I knew I wanted to be an amazing nurse in every way. I wanted to know the science of the body, and I wanted to perfect the art of caring for it. I knew how to study and ask questions, but I didn't know how to define this ungraspable idea I had in my head of the phenomenal nurse I wanted to be. I didn't know how to talk about the deep and trusting connection that I imagined existed between a nurse and a patient or family. Most awkwardly, I didn't know how to answer the frequent question, "Why do you want to be a nurse?" because I couldn't describe the invaluable importance of the potential impact I thought I could have in someone's life. I didn't even know if people talked about such things in nursing, or if the ideas that I couldn't put my finger on were topics that no one really tried to label because they were indescribable, or obvious, or too personal, or just not on anyone's radar.

I wanted to know the science of the body, and I wanted to perfect the art of caring for it.

And then, I came across the book, *Relationship-Based Care,* and later on, *See Me as a Person*. In those pages, I found my answers. I found descriptions, meaning, examples, inspiration, research, guidance, reality, and SOUL. I was thrilled to realize that people DID talk about being fantastic nurses in the ways I had thought were indescribable! Someone had written about what I could not put my finger on! There was a whole world out there talking about it and teaching it and living it. These books were my guide through nursing school and they continue to guide me today in my first job.

I am learning to attune to my patients, look them in the eye, hear what they are saying, ask them how they are feeling, and then respond to their specific needs and circumstances. I know that this small exchange can make a huge impact in the course of their stay on my unit and the long term course of their healing or comfort.

One recent experience comes to mind. After giving the evening medications for about a year, I had built up a pretty regular exchange with a patient who was a person of routine, stability, and control. One night I commented on the sun shining through his window, and he told me he had not been outside for seven years because of a bad experience he had

the last time. If not for what I'd learned in *See Me as a Person,* I might have tried to talk him into going outside, but instead, I just wondered, followed, and held him in my care. I thought it might be healing for him to spend some time outside, but my first concern was what ***he*** wanted. All I could do was offer him the option.

From then on, during my med pass, I would offer to take him outside when the weather was nice. He always quickly declined. He literally never left the room, except once a month when it had to be deep cleaned. On those cleaning days, the staff seemed to dread having to tell him and the arduous process of convincing him to vacate the room. Last month, I volunteered for the task. I explained that it was the cleaning day, and then asked if he'd like to sit in the common room, or if he would like to go outside in the garden with me. With his consent, and my total shock, I wheeled him right outside onto the patio, and for the first time in seven years he felt the summer sun on his skin! I stayed with him the entire time, and when he said he wanted to go back in, we zipped right back inside. He seemed to be unfazed and only slightly pleased with himself.

Although this was not about my feelings, I couldn't help but be delighted! I felt that he trusted me enough that day to try something new that was scary to him, and I was honored. These moments of connection make me want to come to work and do more, learn more, and be more to my patients.

Bio: *Hannah Somers is a nurse at Brookhaven at Lexington, a continuing care retirement community in Massachusetts. She loves getting to know her patients and building relationships with them and their families. Hannah earned her BSN Summa Cum Laude from the University of Massachusetts Boston in 2011. Prior to her career as a nurse, she worked for the Avon Walk for Breast Cancer in Washington, DC. Hannah also has a BA in History from the University of Iowa which she earned in 2004. She and her husband live in Somerville, Massachusetts and love to be outside, travel, and try new things. Hannah can be reached at hannahg880@aol.com or 734-945-6891.*

Transcript of Circle Discussion

Michael:

In our last minutes together, it's your turn to say what's on your mind. And that is not an invitation, as Roger [Nierenberg] taught us yesterday, to tell us what a wonderful book we wrote or what swell guys Mary and I are. This is a time to say what this has actually meant in your practice or to ask questions for more details from any of our panel members, and to exchange, all around the room, with what are the possibilities and what are the casualties related to the things that we came here to discuss today.

There are microphones all around the room and we'll begin . . . right here:

Participant One:

Thank you, all of you, for your insights. It's been a very powerful presentation. I'm an ER physician and a medical director for an Emergency Department, and I find that one of the obstacles to doing what you're talking about is when we pre-judge patients for why they're coming to the ER. In the ER we can't control who comes through the door, and it's very easy to think, "This isn't an emergency; you don't need to be here," and to try to rush them through the door.

What I have found over the years is that those have now become my favorite patients. I get more reward from the times when I turn off my judgment of the mom who brings her three kids in with a fever on Sunday night because she couldn't get into the pediatrician because she has to work during the week, and she can't get a babysitter, and here she is, and all they have is colds, and they're upset because they had to wait a little while, and everyone's huffing and puffing. I sit, and I listen, and I talk, and I reassure, and I give her a bottle of Motrin, and as she leaves she says, "Thank you for your time." I go home feeling better when I do that than when I stomp around and go, "Oh my gosh, I can't believe these people are here."

That also applies to those patients who come in with chronic pain and say, "I don't know what's wrong with me; no one ever figures out what's wrong with me; I've been in the ER 15 times; you guys do all these tests, but you never tell me what's wrong with me." And I'll sit and start a relationship and listen and talk and find out all the things that are going on in their life. Maybe they're upset or they're worried or something's happening and their stomach hurts or their back hurts. I don't have to solve all of their problems, but just sitting there and listening to them and giving them the opportunity to get that out is sometimes exactly what they need. They don't need another round of tests, and they don't need any more medication, and they certainly don't need any more Vicodin. You can make a huge difference just by turning off your judgment about why they're there in the first place. I just wanted to share that.

I don't have to solve all of their problems, but sometimes just sitting there and listening is exactly what they need.

Michael:

But you can't leave us hanging . . . how did you do that?—turn off that judgment. Was there actually a turning point in your career?

Participant One:

There was. I've been doing this for 15 years, and probably for the first five, I was mad and frustrated at the number of people who I couldn't do anything for and who were mad at me because I couldn't do anything for them within my normal ER doctor box. I didn't have a test that was going to fix them, I didn't' have a medication that was going to fix them, and yet they had a problem and, you know, you'd get to that point where you say, "I'm sorry your stomach hurts, I don't really know why—as far as you don't have appendicitis, you don't have gall stones, you don't have anything like that that I can fix here . . . go home; see your doctor." They get very frustrated and they say, "I just want to know what's wrong with me!"

Because that was so unrewarding for me and unrewarding for the patient, I began to look at what could possibly be going on, and many times what was going on was that there's just something going on in their life. They were about to lose their job, or they're going through a divorce, and it's manifesting as a physical issue that you can't do anything about if you don't sit there and listen and talk and hear them out. So it shifted my practice from thinking, "I can't do anything for you," to thinking, "You know . . . exactly what you need is just for someone to sit down and listen to you." When I would offer them that, it shifted everything, but I had to stop being mad about them being there in the first place because it wasn't an emergency. I had to stop thinking, "They're misusing the ER" and all of the other things we say. You've got to turn that off, and then you can be there and be present and hear why they're really there. That way you actually give them what they need and, as Dan [Kopp] was saying, get the reward of the therapeutic relationship which is, "I feel like I actually accomplished something, even though it wasn't treating a physical illness."

Michael:

Well, excuse my presumptuousness, but I'm betting this is on the mind of many of you: What you described is that moment of truth, so to speak, when you changed the way you thought about your patients. That could have gone either way, and I'm just amazed that it went the way it went. Maybe because we just now heard Brené [Brown], I'm inclined to think that, for some reason, you were able to be vulnerable to your own failures.

Participant One:

It was. I was feeling like I was doing the right thing, making the right treatment, doing the right diagnosis, feeling like I was doing everything right, and getting complaint, complaint, complaint, complaint, complaint, complaint, complaint. I kept saying, "I'm doing what's right; why aren't they happy? I'm doing what I'm supposed to do . . . what is wrong with these people?" And what was wrong was that there was something wrong with me. I wasn't connecting with the people the way they wanted me to, and I wasn't getting out of it what I wanted. So it was a moment of truth. It was either get out of medicine, do something else, or figure out how to do it differently.

Michael:

Or just get mad and stay mad and be an invulnerable physician for the rest of your career.

Participant One:

I had a boss who gave me the great gift of telling me to fix it or find another job. I had a boss who very early in my career said, "You've got to fix this or we're going to have to let you go." So . . . I had motivation.

Michael:

Thank you very much. Who else?

Participant Two:

Hello, I'm from Texas and we've been doing Relationship-Based Care for almost two years at our hospital. I'm a leader like Kathleen [Vidal], and I am very blessed to have a staff that has been willing to follow me in my Relationship-Based Care journey, and now we're working on Pathway to Excellence. We've done six *Reigniting the Spirit of Caring* sessions at our hospital.

I am very blessed to have a staff that has been willing to follow me in my Relationship-Based Care journey.

It's a very small surgical specialty hospital in Texas that's a joint venture between Texas Health Resources and about 90 physicians who have ownership in the hospital. At our last *Reigniting the Spirit of Caring* we invited one of our physicians to come, and he stayed the three days and was just astounded. It really brought him back into what he went into health care for. If you haven't done Reigniting the Spirit of Caring at your organizations, I highly recommend it. Now I feel like our next step at our hospital, because our staff gets it, needs to be work with our physicians. Because they are so busy, we struggle with how to get them there, get them involved, and get them to sit long enough to learn and understand and remember why they went into health care. So, I've been thinking I just need to kidnap Dr. Kopp and take him back to Texas with me [audience laughter] and if he could just have a heart-to-heart with our physicians, I believe people would truly have the whole package.

It has made such a difference in the way our employees work together—teamwork, respect for each other and the patients and the families. I really hope that we'll be able to bring our physicians along on the journey with us as we move forward.

Michael:

Thank you . . . someone back here?

Participant Three:

I'm a social worker in critical care. The panel was excellent and brought up an interesting point about what patients remember and what they forget. I deal with a lot families when they have a loved one in critical care, and just spending that little bit of time, just pulling them aside, getting them the coffee, showing them where the meditation room is, goes a long way. Always try to do your homework beforehand. I know it gets hectic, but before I meet a patient I always try to at least read a little of the discharge summary just to see what brought them here, where were they last, and then remember something about them, so I can say things that are meaningful to *them* like, "Are you still home with your cat?" or "Do you have your walker handy?"

I can't tell you how many times, everywhere from church to a state fair, where people bump into me and they'll say, "This is crazy, but do you work in a hospital?" and then it will come back and I'll have

only spent 5 or 10 minutes with them, and they'll remember it.

Michael:

Thank you . . .

Participant Four:

I was particularly interested in your talk about scripting and key words, because I think there's so much pressure on people to raise scores. Press Ganey is famous for putting out, "Well, if you say this when you close the curtain: 'I'm closing the curtain for your privacy' that will help you to make sure that people then know that you care about their privacy." There's a lot of emphasis on that sort of thing and I think the intent is to help people to get it, but it's often coming across as far from authentic because it sounds like you're the person at McDonald's asking, "Do you want fries with that?" It all just comes across as fake. I enjoyed the part in your talk about not needing to be savvy, just being REAL.

So *why* do we have to teach people how to be real? Is it that there are people who aren't getting it or who are missing it . . . or is it us, the way we're setting up the tasks, that we're not *allowing* people to be real. Do we just have a lot of people who shouldn't be in health care? Or is it we who are setting up the environments that don't allow that for people?

Mary:

Let's get a response right here . . .

Participant Five:

At the hospital where I previously was, out in California, we had been transforming our culture in the hospital—we called it sacred work—and we tag-lined that our work was an expression of God's love. That was the work we did every day, and all of the people in the hospital got to create what that was going to look like.

The seed story that got us going down that journey is this: I got a phone call from a nurse one day and she said, "I've got this angry old man patient and he's been ragging on the nurses all morning. I can't deal with it anymore. Can you come help me?" So I went up there (I'm an RN, but I was in pastoral care then) and I introduced myself to this gentleman and he said, "When I put my call light on it takes forever for somebody to come and answer it."

The way the nurse had handled that was to sort of explain life from her world, "Mr. Smith, it's not that I don't care about how you're doing, but I have this many other patients, and when you're a patient in a hospital it's very busy, etc." So of course he did more of whatever he'd been doing because he was not being heard. I just used what we all know—very simple reflective listening, I said, "It seems to me you're saying that when you put your call light on, it seems to take forever for somebody to come and answer it." Then he kind of dropped down to "feeling level" and he said, "Nobody here cares about what I'm doing." And so I said, "So when it seems to take forever for somebody to come and answer your call light, that makes you feel like nobody gives a rip about how you're doing." And this very grown man had tears that formed and I said, "I see your tears; would you like to talk about that?" And he said, "You know, I've lived here for seven years. My two adult children live here. Nobody ever calls or comes by to see me. I've been in your hospital for five days, and nobody's called and nobody's come by to see me . . . ."

So of course when we tell this story in orientation, we ask all of the employees, "Was this about call lights?" "Well, no, it was about a man feeling lonely . . ." and he was so grateful for the visit.

But here's where the story gets to your point. I went out to the nurse, and I said, "Tell me about your experience with this man this morning." Her first answer was, "Well, he just needs to understand how busy I am." I said, "You know . . . you have the proverbial apron on that says 'how may I serve you' . . . it's not his job to make your day easier, etc." . . . but then I said, "Having said that, I'm concerned about you. What were you feeling? What were you experiencing in there with him?" And she immediately began to sob. She didn't even work up from a whimper. She just began sobbing. We went off to a side room, and here's what tumbled out: "He reminds me of my dad, and we never got along, and I wasn't there to say goodbye, and he died three years ago . . ." And for the next five minutes this whole suitcase full of stuff came tumbling out. I didn't say very much. She wanted to have some prayer together at the end; we did that, and she went back to her unit.

Someone made it safe for her to be vulnerable and for her to get connected with what was getting in the way.

Later that afternoon she called me and she had all this energy in her voice and she said, "I don't begin to understand it, but ever since you listened to me this morning, it's like now when the families are upset or they have questions—or the patient . . ." and this was her language, she said, "I can hear underneath what that is. I can hear that they don't have enough information, or they feel scared, or they're not in control," and it's like she's teaching me this class over the phone.

So, of course, in orientation, as we continue to work with this story, we ask people, "What made that shift for her?" Well it was, first of all, someone made it safe for her to be vulnerable and for her to get connected with what was getting in the way. So who we are and what we bring to the encounter has a lot to do with our own willingness to tend to our own healing. That even became one of our taglines: "We only connect to others, to the extent that we're connected to ourselves."

I wept the day I discovered the book *See Me as a Person,* because some of us have been teaching this and have been pressing it for so long, and like Kathleen said, you have given it such clarity and such framework and have legitimized these discussions now. Still, there's so much work that needs to be done for physicians and nurses and all caregivers on their inner life. You can't be awake to someone else if you're not awake to yourself and that's what we learned.

So our work began to be through retreats for nurses and physicians and leaders and others. We spent the day simply getting in touch with who we were and what got in the way and seeing our own wounds.

Michael:

Before we move the mic from one person to another, I want to make sure that you take note of a key principle we just learned here . . . and it's directly related to what you [Participant 4] asked.

Many of you in this room who are leaders especially, must be wondering about the nurses at your place who would have treated that man the way that nurse treated that man. I want you all to be wondering, "What is it that she knew, or imagined at least, about that nurse that allowed her to not react to her less than exemplary behavior and instead to give to HER what we've been talking about giving to patients? What is it in us that allows us to imagine that someone, whom we may rather not be working at our hospital, is actually a person with a father who she didn't get along with

and whom she sees in this patient? That's a miracle . . . and I'm sure you caught it.

Participant Six:

I want to go back to what the emergency doctor mentioned about judgment. Mary and I were talking about judgment as it relates to psych patients, but this story really resonates with what we were talking about. Last year I was working with a team of inpatient nurses, and they were talking about a patient who had been on their unit for going on 30 days. The discussion around the table was, "Oh my gosh; that guy is such a pain. He is so angry." I come to find out he's heavy set, weighs close to 360 lbs., doesn't want to be washed . . . he smells . . . this is what they were saying about him.

Then one nurse said, "Well you guys, you know his story, don't you?" Then silence. And I said, "What's the story?" And she said, "He's been here for 30 days because, for one, he doesn't have insurance. Two, we can't find anywhere to send him. The caseworker has been looking for a place to send him. He has no family, nobody comes to visit him, and he's angry and he's hurt and," she said, "He even said to me, 'You guys look at me like everybody else looks at me. Nobody wants me. And because you can't find a place for me, you treat me like crap.'" And I said, "You haven't told these guys this?" And she said, "Not until now."

Ever since then, I have passed the message that you have to share when you know something about a human being. You have to share the perspective of that person, because it might change the way your whole team takes care of this person. That was a heavy, heavy day,

Participant Seven:

I'm from Covenant HealthCare in Saginaw, Michigan, and I wanted to bring us back to *The Therapeutic Relationship Workshop* because that's how we've chosen in our organization to bring Relationship-Based Care in. We have five people who are licensed by CHCM to teach the two-day workshops, and I just wanted to share with you some of the experiences we have seen with that.

The book itself, *See Me as a Person,* was a wonderful vehicle all on its own. We did book studies, and we did discussions that brought in the nurse managers. But the book in concert with the two-day workshop has made such a difference already. We have our front-line nurses coming to this workshop on their own time. We did not have to pay them to come. We fill the workshops, people are talking to one another about it, and it's changing the whole concept of how we see our patients.

I think, in answer to that question, "How do you teach people to be real," . . . if they get the concept that the person in the bed is real, they can't help but be real.

I know that *The Therapeutic Relationship Workshop* is one of the newer concepts, one of the newer offerings Creative Health Care Management has, and I just wanted to put it out there to you that anybody who wants to ask about it, these are our facilitators here. Nancy [Dole] is our lead facilitator, and we'd be more than happy to share with you some of the things that have come out of some of those two-day workshops that we are just so blessed to have at our organization.

Mary:

Two other comments and then we're going to ask you to do a little bit of an exercise so we can garner some of the gems that are in this room. We wish we could hear from all of you. I wish we had all day because the conversation is getting so rich and wonderful. Here . . .

Participant Eight:

I am not a health care provider in the world of medicine, but I'm a care provider in the world of therapy. One of the first things I learned in my work, was that I cannot create sacred space for you if I haven't cleared my own sacred space. And seeing you as a person is impossible if I can't even see clearly who I am as a person. The level of importance of really understanding why I'm angry, why I'm impatient, why I've become intolerant of my clients, and why, if you don't get better sitting in front of me, I get mad at you instead of remembering that you're my client. You're there for me to provide care for *you.* So that was my first brief point: Creating my own sacred space internally has to happen before I can create it for you externally.

Then I also wanted to share a really brief story that I hope will help the providers. My aunt recently died, and she had been in intensive care for over a week and when my cousin called and said, "Come," I came. This was an aunt who raised me, so she was like a mom. In the hours before her death, as her respiratory rate was going down, and all the machines were slowing down, all of my cousins left, and every one of her family members left . . . and said, "I can't see her die."

This was a woman who brought me back to life.

After they were all gone, I remember one huge male nurse in the room who started to clean her room *before* she died. He was cleaning up *stuff,* and I said, "Please . . . I will help you clean her room if you wait." I said, "Stop . . ." And not only did he stop, but he said, "What do you need?" And I said, "I need to get in bed with her . . . I need to get in bed . . . I need to hold her." And he said, "Okay." He cleared the side of her bed—all the machines—and he let me get in bed and hold my aunt while she died. I will never forget that. So I stayed and helped him clean the room. He helped me and I helped him, and I will never forget that nurse. So . . . let us lie in the bed, let us get close to our people even when they're dying. Let us do what we need to do. Thanks.

I cannot create a sacred space for you if I haven't cleared my own sacred space.

Mary:

One last person . . . yes.

Participant Nine:

Hi, I just wanted to say that the combination of hearing, Marcus, your story, and that meditation piece [COAL from the *See Me as a Person* CD] so deeply moved me to tears that I thought I was going to have to leave the room. It was so powerful, it was so moving, and it's really why I became a nurse was to make that kind of impact.

I also have a question for Marcus. To hear your story about Jennifer, I was just curious to know a little bit more about her reaction. I know you said she had no idea about the impact that she had on your life, and for me, I hope that, whether I know it or not, I can create that same impact for somebody. If I could just play that loop in my head every day when I walk through those doors, of, "See me as the person I really am, not the way I am here now" . . . "understand that when it gets so crazy in families, a lot of time it's motivated by fear and misunderstanding."

Again, I was just curious about her reaction when you told her the impact she had.

Marcus Engel:

Well instead of explaining her reaction, you can watch it! You can watch it at Imheremovement.org. It's under the tab that says Marcus Meets Jenny.

Again, at the time, she was a 20-year-old. Obviously she's no longer a 20-year-old, and she's no longer a patient tech, but she's actually the clinical nurse manager of the surgical ICU, which is where she dropped me off that morning. So . . . it's impossible for me to put myself into the mindset of somebody. She knew about me. She found out that I was there and what I was doing and what I had been doing, 12 hours before we were reintroduced. She took that night and read my book, read about herself in my book, had no idea she was in a book or that she did inspire the title of a book . . . . So, I don't know. I can't put myself in that place. And again, just like with Barb, it's one of those relationships where I feel indebted. I am in debt to her for her presence that night.

In addition, as part of the I'm Here Movement, we have created two national awards—one is the Jennifer Award, one is the Barb Award. The Jennifer Award is for any person who works in emergency services, and the Barb Award is given every year to a bedside nurse. They had the inaugural award this last year, and we're going to be able to do that from now on for people who show those kinds of qualities in their caregiving.

Mary:

Thank you, Marcus.

Participant Take-Aways

Surprising Insights

All healing occurs in the context of relationship.

I am as I am, and I need to allow the true me to be present.

There is a big difference between service excellence behaviors and real authentic connection.

Key words at key times and rounding don't raise Press Ganey scores because neither are about the patient, but rather about the scores. Putting the patient at the center where they can drive their care, makes them feel more cared for.

Experiencing the sharing of thoughts from the MDs was very enlightening. Hearing that they struggle in the same way nurses do was in some ways surprising. This experience will help me have conversations with my MD colleagues.

Families Matter

The potential impact you can have on an individual or family is profound. Treat patients and families as you would want yourselves or your family member treated/cared for.

"Treat" the family member also, as they can be of great value to help in caring for the patients ie: history, background, etc.

Open, Vulnerable, Listening Deeply

Authentic caring involves risk. Joy exists in our authentic human connection.

I learned through this session that it's important to show your vulnerability to the patient as you make the attempts to understand and care for your patients and families.

With this experience I'm taking away the importance of being vulnerable and open, not only to my loved ones, but those I care for. To listen—not advise always, but listen to my patients and find what's important/worrying them.

Practitioners have lost the joy in their work because they have lost the ability to be vulnerable with their patients. Caring is a buzzword—care needs to be real and scripting sounds fake. We are here for our patients, not the scores.

Renewed, Rejuvenated, Refocused, Reaffirmed, Reattuned

I feel reinspired and regenerated, reaffirmed and hopeful that the caring work that we as nurses do every day does make a difference. I will go back as a nurse manager and hope to reinvigorate my staff.

I am in the right field. I need to be and work around people who feel the way the people in this room feel about the therapeutic relationship.

Connection is Key

Miracles happen when we suspend judgment and stop our own reactions and simply be and listen fully with the patient. Sometimes this is all the medicine they need.

Caring for patients is a privilege—we are fortunate to be allowed into their space (they are not in ours).

Good care is not about response time and scores.

"Busyness is not of the devil . . . it is the devil." ~ C. G. Jung.

Curiosity, Openness, Acceptance, Love. Seeing a patient as a person and creating that connection. Being present—nothing else matters in that moment except the patient.

Stop the scripting. Involve the docs.

Practical Take-Aways

Remember that although the health care provider is comfortable in a hospital and understands what is going on, the patient may feel like he/she is in a foreign country.

Simple things, to invite the family in such as providing "insider information" about coffee, can create the right relationship.

Everyone has a story and they carry that story with them in everything they do, think, feel—this is true for both caregivers and patients—the stories need to be shard to create a healing environment.

I now must remember not to judge.

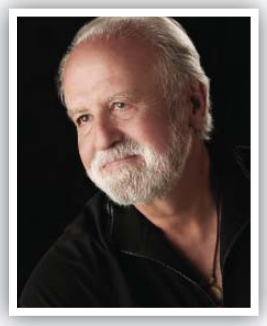
Biographies

Mary Koloroutis (Facilitator):

As a co-creator, author, and editor of the *Relationship-Based Care* series of books and seminars, Mary helps health care organizations envision and implement a framework for delivering world-class care grounded in caring research, human values, and ethical principles.

This approach is evident in her most recent work, *The Therapeutic Relationship Workshop* and the book *See Me as a Person,* both co-authored with psychologist Michael Trout. This program emphasizes the importance of establishing a therapeutic connection with each person needing care as a fundamental condition for healing. It also asserts the importance of vulnerability, self-knowing, and self-compassion as the pathway for providing compassionate care to others. Mary earned her BSN from Mary-Hardin Baylor University in Temple, Texas and an MS in nursing administration from the University of Minnesota. She is a Vice President and Senior Consultant with Creative Health Care Management and currently lives in Champaign/Urbana, Illinois. Mary can be reached at mkoloroutis@chcm.com or through www.TheTherapeuticRelationship.com.

Michael Trout (Facilitator):



After completing undergraduate and graduate studies in philosophy and psychology, Michael completed his specialized training in infant psychiatry at the Child Development Project, University of Michigan School of Medicine.

Michael directs a private institute engaged in research, clinical practice, and clinical training related to problems of attachment in early life, working principally with children of loss and trauma. He was the founding president of the International Association for Infant Mental Health, was on the charter editorial board of the Infant Mental Health Journal, served as Vice-President for the United States for the World Association for Infant Mental Health, and currently serves on the professional advisory board for Attachment Parenting International.

In addition to his authorship of a number of books and journal articles in his field, Michael has produced 15 documentary films that are in use in universities and clinics around the world, including four films on the unique perspective of babies of divorce, adoption, loss, and domestic violence.

His newest book, co-authored with Mary Koloroutis and published in 2012, is on the nature of the therapeutic relationship, and is entitled *See Me as a Person.* His work on this book and its companion workshop, *The Therapeutic Relationship Workshop,* have given Michael the opportunity to impact (and learn from) clinicians in a wide range of disciplines. Michael can be reached at mtrout@infant-parent.com or www.TheTherapeuticRelationship.com.

Marcus Engel (Voice of the Patient):

Marcus is a professional Speaker and Author who provides insights and strategies for excellent patient care. Marcus is a 2012 graduate of the Masters in Narrative Medicine program at Columbia University in New York City. His books are routinely utilized by major health care systems and universities across the country. Marcus is a leader in the field of patient experience and the founder of the "I'm Here Movement." Marcus can be reached at Marcus@marcusengel.com.

Marvelyne Engel (Voice of Family Member):

Marvelyne is a writer and speaker who helps heal invisible wounds. After two decades of serving in counseling ministry, she is now pursuing an MS in counseling with a focus on helping those dealing with traumatic events to find their own authentic path to healing. Marvelyne is a parent of three, all of whom were patients at more than one point; she is also a relative of several people living with chronic illness. She is the wearer of many hats: wife, mom, daughter, sister, friend, adventurer, lover of shoes, and collector of stories. Learn more at her blog www.aLittleMisadventure.com.

Nancy Dole (Voice of Nurse):

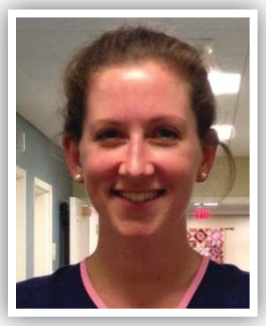
Nancy is a proud member of the nursing profession who is dedicated to caring for children and their families in her home community of Saginaw, Michigan. She has been a member of the pediatric nursing staff for more than 29 years, providing technical and spiritual support to children and their families while sharing time as the nursing educator for the Pediatric Department.

Since her first exposure to the tenets of Relationship-Based Care, Nancy has been passionate about sharing these concepts with others. Her goal is to bring awareness of Therapeutic Relationships to the 4000+ employees of her organization. Nancy Dole can be reached at ndole@chs-mi.com.

Kathleen Vidal (Voice of Nurse/Researcher):

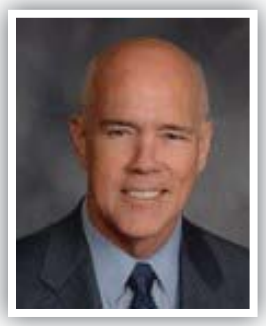
Kathleen is Director of Nursing Practice Development at University Hospital Case Medical Center. In this role, she supports the University Hospital System in education, implementation, outcome monitoring, and research of its interdisciplinary relationship based model of care. Kathleen can be reached at Kathleen.Vidal@UHhospitals.org.

Hannah Somers (Voice of New Clinician):



Hannah is a nurse at Brookhaven, a continuing care retirement community, in Lexington, Massachusetts. She loves getting to know her patients and building relationships with them and their families. Hannah earned her BSN Summa Cum Laude from the University of Massachusetts Boston in 2011. Prior to her career as a nurse, she worked for the Avon Walk for Breast Cancer in Washington, DC. Hannah also has a BA in History from the University of Iowa which she earned in 2004. She and her husband live in Somerville, Massachusetts and love to be outside, travel, and try new things. Hannah can be reached at hannahg880@aol.com.

Dan Kopp (Voice of Physician):



Dan is a 1969 graduate of the U.S. Military Academy at West Point, NY, and a 1980 graduate of the University of Alabama School of Medicine in Birmingham. He trained as a Family Physician at Madigan Army Medical Center in Tacoma, WA, from 1980-1983, and has been board certified in Family Practice since that time. He's served as the Chief Medical Officer at the University of Missouri Health Sciences Center and School of Medicine in Columbia, MO, Northeast Health in Albany, NY, and most recently at Faxton St. Luke's Healthcare in Utica, NY.

A retired U.S. Army Colonel after 32 years of active duty, having done 25 years in full-service Family Medicine in multiple assignments around the world, Dan is excited to now be working as a Consultant for Creative Health Care Management. Dan Kopp can be reached at dkopp@chcm.com.

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