Published in final edited form as:
J Radiol Nurs. 2012 December 1; 31(4): 114–119. doi:10.1016/j.jradnu.2012.08.001.

A Better Patient Experience Through Better Communication

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Abstract

The transformation of healthcare from a seller's market to a consumer's market has pushed the element of patient satisfaction into the forefront of various medical facility evaluation tools, including those used by Medicare when weighing reimbursement to hospitals for patient care. Research has identified good communication skills to be a key factor in ensuring better patient outcomes, and nurturing patient satisfaction. Because of the growing amount of money at stake for patients' satisfaction with a facility, the communication skills of individual healthcare providers are bound to impact their employees' reimbursement, bonuses, and promotion options. Although the dangers of "poor communication," are evident: "poor communication" is a primary reason for filing a law suit in >80% of cases (Avery, 1985). Identifying the characteristics of "good communication" has been difficult. One factor that adds to the confusion is that research has found some long accepted codes of professional communication protocol to actually be counterproductive. Another factor that adds to the uncertainty is that accurate interpretations of some communication events are counterintuitive. Fortunately it has been possible to extract observable, proven, and teachable "good communication" behaviors from large-scale trials in the radiology department. The resultant Comfort Talk™ approach to communication includes rapid rapport techniques, patient-centered talking styles, and use of hypnotic language. This article overviews some of the Comfort Talk™ approaches to patients interaction and provides operational summaries of a sampling of specific Comfort Talk™ communication techniques, which nurses, technologists, and other healthcare workers can implement in their own practices.

Keywords

Satisfaction; Pain; Anxiety; Communication; Comfort Talk™

INTRODUCTION

Good communication skills are indispensable to basic concepts of nursing care as communicating effectively can help reduce the risk of medical errors, ensure better patient outcomes, and nurture patient satisfaction. A good patient experience– while considered merely desirable in the past – is moving center-stage. The transformation of healthcare from a seller's market to a consumer's market includes patient satisfaction in the definition of quality (Vuori, 1991). More pressingly, Medicare will examine patient satisfaction scores when reimbursing hospitals, and better performing hospitals will win out on the incentive. It seems very likely that other insurance carriers will soon follow suit. Effective October 2012, the Center for Medicare & Medicaid Services will withhold 1%, and in 2017 it will withhold

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2% of regular reimbursements based on performance, currently an estimated $850 million (Landro, 2011). Hospitals can make up for the cuts and earn additional payments if doing well on two measures: quality and patient-satisfaction surveys known as Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS). Patient experience makes up for 30 percent of the total bonus payments! As with other communication definitions, the HCAHPS input questions elicit ratings for nursing behaviors, which may be obvious but are typically subjective: "How often did nurses treat you with courtesy and respect? How often did nurses listen carefully to you? How often did nurses explain things in a way that you could understand?" Of special interest are questions on pain management, which include: "How often did the hospital staff do *everything* they could to help you with your pain?" "*Everything,"* includes pharmacologic and also non-pharmacologic means e.g. the way one talks to patients. Considering how much money is at stake for patients' satisfaction with a facility, it will only be a question of time until the communication skills of individual healthcare providers in these institutions will impact their employee's reimbursement, bonuses, and promotion options.

The urgent and growing need for developing effective "good" communication skills is evident. In fact, "poor communication" is a primary reason for filing a law suit in >80% of cases (Avery, 1985). What constitutes "good communication," however, is more elusive. Good communication is often described by patients in only vague terms. What's more, research has discovered that a number of routine "professional standard" communication assumptions customary for most institutions are actually counter productive. One example is warning a patient of upcoming pain with pain-laden descriptors given under the goal of "being honest" (Lang, Hatsiopoulou et al., 2005). Another is always remaining calm, even attempting to smile, no matter how desperately a patient acts out because maintaining "professional demeanor" is sacrosanct. Fortunately it has been possible to extract observable and teachable good communication behaviors from large-scale IRB-approved trials in the radiology department. The resultant Comfort Talk™ approach to communication includes rapid rapport techniques, patient-centered talking styles, use of hypnoidal language, correct wording of suggestions, and the optional reading of self-hypnosis scripts. While full practice requires some training, several of the skills can be easily assimilated by developing greater awareness of one's own and the patient's communicative preferences and the subsequent adaptation to the patient's needs. This article provides an overview of some of the Comfort Talk™ approaches to patients interaction developed over 18 years of research and provides samples of specific communication techniques, which nurses, technologists, and other healthcare workers can implement immediately.

METHODS AND PERSPECTIVES

The Comfort Talk™ method trains healthcare professionals in "talking style" techniques that are complemented with hypnotic language allowing them to help reduce the anxiety, pain and distress of their patients. Comfort Talk™ grew out of years of IRB-approved, federally-funded research research (Lang et al., 2002; 2006; 2005; 2008) which the author and members of her teams (subsequently referred to in this article by the personal pronouns: *we* and *us*) conducted in the radiology suite with non-pharmaceutical patient sedation.

Comfort Talk™ techniques tap into the mind's natural ability to block pain and reduce stress. It is a no nonsense, straightforward approach to patient relaxation or sedation without the use of medication. Learning from facilities that have engaged in this approach we were able to identity what drives the comfort levels of healthcare providers in difficult communications. This insight can be used equally well by individuals striving to improve their patient interactions. Outcome-validated talking styles, skills that allow healthcare professionals to express their empathy appropriately, and techniques that diffuse patients'

stress and pain can be taught to radiology personnel (Lang & Berbaum, 1997; Lang et al., 2002; Lang, Sood, Anderson, Kettenmann, & Armstrong, 2005). Often, just awareness and small changes in talking style—neither of which take any extra time—can avoid misunderstanding and enable the rapport needed for a mutually satisfying interaction.

Patients want to feel like they have been treated caringly, respectfully, and unhurriedly (Levinson, 1994). But there is a caveat: even communication approaches based on empathy with extra care and time commitment can precipitate adverse events in interventional radiology patients unless the interaction is structured to help patients help themselves (Lang et al., 2008). To help patients help themselves is the key to success. The very good news is that when healthcare professional use the Comfort Talk™ techniques towards this goal, they actually save time - and money for their institution.

We estimate that annually in the US 425 million to 1.4 billion Dollars are lost due to patients being unable to complete their MRI scans due to claustrophobia, pain, or disruptive patient motion (based on 33 million scans performed annually with a 2.3% non-complete rate (Dewey, Schink, & Dewey, 2007), and a technical + professional reimbursement rate between $500- $2,000). Just knowing how to talk to distressed MRI patients can significantly reduce this expense – and patient hardship (Lang, Ward, & Laser, 2009). Similarly in interventional radiology, on the average $338/case can be saved just by intent to offer a Comfort Talk™ approach (Lang & Rosen, 2002).

Communication – The Healthcare Professionals' Perspective

Within the scope of our current NIH-NCCAM grant (1R43AT006296), we were able to query the comfort levels of MRI technologists and nurses in three hospitals with a pre-training questionnaire we had previously developed for use in communication training with Radiology trainees (Lang, Sood et al., 2005). Being praised as the "best technolgist/nurse/ doctor" invariably elicited high ratings for generating comfort among radiology personnel. In the same questionnaire, higher levels of discomfort were listed across sites and professions in situations where healthcare professionals had to deal with individuals who (1) display overt hostility, (2) show passive aggressive behavior, (3) avoid eye contact, and/or (4) whom they dislike. For this reason we believe that the "difficult communication" approaches in medicine that emphasize content e.g. "what to say" without first establishing rapport have difficulties succeeding. In our experience, the best knowledge of what should be said dissipates in thin air as soon as a person feels stressed or lacks rapport with a conversation partner. On the other hand, feeling in rapport greatly helps to actually come up with right words. Then answers are felt genuinely and are not an escapist mechanisms to avoid reminders of one's own vulnerabilities or fears. Therefore, establishing rapport quickly – particularly under adverse conditions – is critical.

Communication – The Patients' Perspective

Visiting the radiology department is stressful for the patient (Mueller, Biswal, Halpern, Kaufman, & Lee, 2000; Peteet et al., 1992). What may be considered minor by radiology personnel for being "just" a diagnostic test can elicit distress similar or worse than that provoked by having invasive, more risky cancer treatment such as chemoembolization (Flory & Lang). Uncertainty of diagnosis turns out to a be major stressor (Lang, Berbaum, & Lutgendorf, 2009).

Patient stress can have two side effects that can derail good communication rapidly and irreparably: Patients can become stuck "in their ways" or preferred modes of communication which may be at odds with those of the treating personnel and lead to misunderstandings; and providers may "feel" for the patient but not know how to funnel this empathy in a way

that helps the patient. Instead the providers might present behavior to mainly diffuses their own internal tension and actually makes things worse for the patient (Lang et al., 2008).

SPECIFIC COMFORT TALK™ COMMUNICATION TECHNIQUES

For a more comprehensive study of the following techniques, the reader can refer to *Patient Sedation Without Medication* (Lang & Laser, 2011). Once one is aware of and trained in these techniques, patients' satisfaction increases even when not making extra effort – using the Comfort Talk™ techniques just becomes second nature (Lang & Berbaum, 1997).

Establishing Instant Rapport

Rapport comes first. One cannot stress the importance of the initial interaction enough. We conducted three large prospective randomized trials with >700 patients testing Comfort Talk type interventions in helping patients through vascular and renal procedures (Lang et al., 2000), large core breast biopsies (Lang et al., 2006), and embolizations of hepatic malignancies and uterine fibroids (Lang et al., 2008). In all three trials, there were three groups: (1) a standard care group that received the routine treatment customary for the institution (2) an empathic attention group, in which a provider displayed rapid rapport techniques, and (3) a self-hypnotic relaxation condition in which a provider displayed rapid rapport techniques and read a short standardized script of about 2 minutes duration. All patients received local anesthetics, and with the exception of the breast biopsy patients, all had access to fentanyl and midazolam in a patient-controlled analgesia model. In all three trials, pain increased linearly over time under standard of care – and significantly less so or remained flat in the self-hypnotic relaxation condition. The empathy condition had varying outcomes depending on the behavior of the remainder of personnel in the room. Interestingly, the degree of increase in pain over time was quite similar among the patients assigned to standard care in the three trials - despite waste differences in the invasiveness of the procedures. This lead us to stipulate, that what happens in the first minutes of the encounter will determine how patients process distress thereafter – and that a short investment of time at the onset will greatly pay off later. The key, hence, is to make the most out of these first minutes - or even seconds – of an encounter to build rapport.

Rapport ensues when people feel they have something in common. This may be based on their background, appearance, dress, or likes. Communality in some of these domains is not achievable at a moment's notice – but communality in behavior can be attained immediately and is one of the most critical elements in establishing rapport, as we have observed in multiple patient-provider interactions.

There are different ways in which people prefer to experience the world – their sensory preference may be visual, auditory, kinesthetic, gustatory, or olfactory and they may prefer to express themselves predominantly in terms of one of these preferences. For example, a person with an auditory preference might use sound-based verbiage such as "This rings true," That sounds great" - and if your response then will be "I hear you," rapport ensues much faster than if you were to choose an "I see," a visually based statement which may be YOUR preference.

People also have different preferences for being close or distant to others. While most people can adapt to a conversation partners preference under relaxed conditions, they do tend to become stuck in their own preference under stress. That is the time where it is essential for the healthcare professional to adapt to the patient's preference and not insist on his or her own (considering that a stressed patient may, in turn, stress the caregiver). Otherwise rapport can become impossible from the start (Grossman, 2012).

Matching the patient's initial demeanor, disposition, and rhythm is the fastest, simplest, and most powerful way to establish rapport – even if that may mean to raise one's voice first in sync with a loudly complaining individual. The idea is that such "unsuitable" behavior is only maintained for seconds as a measure of acknowledgement of the conversation partner's emotional state. This sync creates a quick bond from which the healthcare professional then can "lead" the patient to a better place –leading for example by quickly lowering the voice from the initial loudness, or becoming more measured in movements if the initial matching included gesticulation, or breathing slower and deeper from initial shallow rapid ventilation. Sometimes matching requires letting go of ingrained perceptions of what professionals "do." For example, medical training often emphasizes keeping an open body position and remaining calm and soft-spoken regardless of how upset or challenging the patient may be. Being low-key in front of an irate person however may infuriate this person even further. Even smiling is suggested as means to reach patient satisfaction – one can just see how that may make a patient who is distressed feels mocked (Thiedke, 2007).

The background of matching and leading dates back to the theories of Neurolinguistic Programming (Dilts, Grinder, Bandler, & DeLozier, 1980) and found scientific support in the detection of mirror neurons (di Pellegrino, Fadiga, Fogassi, Gallese, & Rizzolatti, 1992). The readers may discover how they too intuitively match someone's body position under relaxed conditions (Miles, Nind, & Macrae, 2009). They likely feel comfortable when others in their surrounding hold their arms or legs just like they do – and how that can suddenly change when the conversation turns into more difficult domain. The key is to keep matching in that situation!

Interpreting Eye Contact

Another element that can quickly derail a situation is misunderstandings about eye contact and eye movements. Medical training often emphasizes to maintain eye contact, but direct eye contact is considered inappropriate—sometimes outright insulting— in some cultures. The Comfort Talk™ advice is to adapt to subtle clues of the conversation partner's preferences.

As we found in our questionnaires on comfort in conversations, the majority of our queried radiology personnel felt uncomfortable when a conversation partner averted his or her eyes from them during a conversation. People untrained in eye-movement interpretation tend to impose negative or positive messages on the eye movements of their conversation partner in these settings. Even friendships and interviews can risk derailing based on this misconception (Lang & Laser, 2011). Eye movements, however, are mostly involuntary and may indicate nothing more than the partner's way to access information. For example, when you think of what you had for dinner last night you might notice that your eyes shift to the left and possibly upward. If asked what you intend to do Sunday in a week from now you may notice your eyes shifting to the right – and likely up – while you are searching for the words of your description. Most people shift their eyes to the left when they access memory and shift their eyes to the right when they construct new information or seeking words to go with it (Dilts et al., 1980).

Additionally, sensory preferences come into play with eye movements. For persons with a strong auditory preference good listening may require them NOT to look at you, but to look to the right or left of you. Thus, not returning you gaze means they are more attentive – not ignoring you or hiding something. Visually-anchored persons will look upward when thinking about what you are saying. Kinesthetically-anchored persons may shift their gaze downward to take in what you are communicating. They also may prefer wording including sensations, and your question "What do you feel?" will be more magic in its effect than a "How does this look now?"

Understanding Negative Suggestions

Negative suggestions to patients, such as “this will just be a pinch and a prick,” or “it won’t hurt much,” are ubiquitous in healthcare encounters. They are well-meant but produce the contrary outcome (Cyna & Lang, 2011). Such verbiage that mentions “the pink elephant in the room” and draws the patient’s attention to pain and undesirable emotions is likely to become a self-fulfilling prophesy. In a study in which we evaluated 159 videos of interventional cases, we found that warning patients from stimuli with such wording, even when preceded by “not much” or “little,” significantly increase pain and anxiety (Lang, Hatsiopoulou et al., 2005).

One often hears the objection, “But I have to be honest with the patient, and I know what I’m about to do hurts.” And because of the self-fulfilling nature of such statements the persons voicing the concern are correct- thus perpetuating and driving up this spiral of healthcare provider-induced pain: If one mentions pain, the stimulus will be experienced as more painful, leading to even more warning the next time it is applied, leading to more warning etc. It is enough to state what is about to happen in the procedure, for example, “I will start placing your IV now,” without adding either predictions nor promises of an outcome one can’t know anythow; in other words leaving the patients to what I like to call the patients’ right to their own experiences. Alternately, one may offer the patient to focus on a sensation of cool or warm or tingling instead – the choice engages the subconscious mind to reflect and while absorbed in that task divert attention from disagreeable components of the experience.

Use of Scripts

In addition to building instant rapport through nonverbal communication cues and correct use of suggestions and language the Comfort Talk™ method is based on helping patients initiate self-hypnosis to lessen stress and pain, increase control and satisfaction, and manage physiological risk. When contemplating using this aspect of patient communication, it is helpful to consider the advantage of knowing what you are going to say. When patients are undergoing procedures or medical tests in which they need to stay still for extended periods of time – such as MRI examination – and when painful stimuli are involved – such as during biopsies and interventional procedures – it is helpful to read a self-hypnotic relaxation script. Depending on the needs, provisions for pain and worry management are read only when needed. Since choice of words is critical in structuring the patient’s experience, reading a script avoids the need to memorize and also helps standardize the approach in an institution and to develop a helpful vocabulary. Reading a script even allows for one person to take over from the next, which proved helpful in our clinical experience when people had to answer calls or leave the room. Using a script can be as short as 60 seconds and with all provisions takes 3 minutes when patients are very anxious. However, even the 3 minutes are well worth it. In the “Lancet Trial” we showed a saving of 17 minutes room time for patients who had the script read in the interventional radiology suite as compared to standard care (Lang et al., 2000).

Research has also shown that pre-procedure anxiety is a strong predictor of intraprocedure pain, anxiety, and duration (Schupp, Berbaum, Berbaum, & Lang, 2005). Patients who want additional attention will get it – how much easier to give it upfront when everyone can relax than waiting for the middle of a tough case when emotions and risks run much higher. The script we used in our prior trials is published (Lang et al., 2006; Lang & Laser, 2011) and has recently changed very little after having been tested and refined for nearly two decades. With some training in the method any compassionate healthcare provider should be able to use it appropriately and successfully.

CONCLUSION

By communicating better with their patients, healthcare professionals will not only improve patient satisfaction, they will improve their own job satisfaction as well. Awareness of each patient's communicative preferences and understanding their preferences will allow healthcare professionals to adapt to the patient's state of mind greatly facilitating the communicative process. Also, the correct use of suggestions will further ease the path towards a mutually satisfying interaction between healthcare professional and patient. Finally, a complete Comfort Talk™ approach including the use of hypnoidal and/or scripted language will further enhance communication - allowing medical procedures to progress more efficiently, more safely, and more comfortably for both patients and providers.

Acknowledgments

The work for this manuscript was supported in part by the National Center for Complementary and Alternative Medicine of the National Institute of Health under Award Number R43AT006296. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute of Health.

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