# NAVY MEDICINE

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# Patient Encounter Skills Development

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ALL OF US IN NAVY MEDICINE ARE COMMITTED to providing the best possible medical care to our beneficiaries. Despite this commitment, we periodically encounter negative comments regarding Navy medicine and military medicine in general both in the media and from our line counterparts. It is difficult to reconcile these unfavorable remarks with the excellent clinical skills possessed by the Navy physicians, nurses, and Hospital Corps staff with whom we work in the hospital. Recently, however, I gained a painful insight into how such negative attitudes may be formed.

An elderly gentleman approached the window in our eye clinic and asked the corpsman at the desk if he could make an appointment to have his eyes examined. The corpsman inquired as to his duty status and upon finding that the patient was a retiree, informed him that our clinic did not see retirees. The gentleman then left in obvious disgust, convinced that the Navy had betrayed his trust and failed to provide him with the medical care which he had been promised. My reaction on hearing this exchange was a sense of profound frustration. This frustration was born of the fact that the information provided by our corpsman was both incorrect and delivered in a brusque, matter-of-fact manner.

In ophthalmology, we see a preponderance of diseases of the elderly. More than 75 percent of the ophthalmology patients that we see on a routine day are the retired patients or their dependents who comprise the majority of our clinic population. Because of the requirement to see active duty and dependents of active duty on a priority basis, however, new "routine" consults for retirees are limited primarily to surgical problems. Emergency consults for retired personnel and their dependents are still seen. The corpsman on duty at the front desk did not take the time to convey these facts in his response nor did he indicate any sorrow for our being unable to meet the patient's needs or make any offer to help the patient arrange for care through CHAMPUS.

How is such a problem best handled? The traditional Navy approach to dealing with a shortfall in performance is to provide prompt negative reinforcement to the individual responsible. The traditional approach, however, is best avoided in this type of situation. First of all, it just doesn't work. Negative reinforcement may be an effective and appropriate method of improving performance in many military situations, but harsh words are a poor tool with which to fashion a well-informed and compassionate health care provider. The second point is that this approach wastes a potentially valuable asset. TQL (total quality leadership) techniques teach us to obtain the help of the individuals most familiar with a problem in finding a solution.

In reflecting on this issue, several key facts must be considered. In general, the quality of the health care personnel working in a Navy hospital equals or exceeds that of their counterparts in a civilian hospital, but these outstanding professionals must function in a large bureaucracy already burdened with a myriad of regulations and which is chronically overcrowded. Our manpower structure is such that clinic reception and appointment staff are usually junior enlisted personnel. These individuals are required to meet the public, perform preliminary triage, and explain clinic procedures; they must also respond to patient complaints about long waits, shortages in available appointments, and other inconveniences. Our junior corps staff are typically fresh out of high school and "A" school and have had little or no training in public relations skills. It is precisely this relatively weak aspect of Navy medicine which often makes the strongest impression on our patients.

Frequently, patients don't know if their medical condition has been treated optimally. An elderly patient with

glaucoma will not know whether or not our recommendation that he/she have laser surgery is a better or worse choice than treating his/her condition with a different eye drop or proceeding directly to more invasive glaucoma filtering surgery. Patients do, however, know whether or not they have been treated compassionately and courteously by the hospital staff and it is this facet of their care that they remember.

Our department has devised a novel way to approach this problem which has been extremely successful. In the following paragraphs, I would like to describe our methods, demonstrate how they can be applied in a specific situation, and show how they have improved the care that we provide to our patients.

### Step 1

The problem is first outlined to the clinic staff. The importance of conveying the positive, caring attitude that we wish to have our patients remember after their treatment at our facility is emphasized to all department personnel. Our goal of ensuring that patient encounters in our clinic are handled as skillfully as possible is clearly stated and the assistance of the staff in achieving this goal is solicited.

### Step 2

Everyone in the clinic is requested to compose a list of the most frequent or most difficult questions and situations with patients they have encountered in the clinic.

### Step 3

The individual lists are compiled and typed. Our composite list had 16 such questions. Examples included:

"How much longer am I going to have to wait to see the doctor?"

"Why does it take so long for my glasses to come in?"

"I forgot my appointment? Can I get another one?"

"I am a glaucoma patient followed at the Naval Hospital in Jacksonville and I ran out of my medications? Can I get a refill?"

### Step 4

A copy of the composite list is then distributed to each staff member. Each individual in the clinic is requested to take the list home and write down the best possible response that they can come up with for each question. Examples of less desirable responses are also solicited.

### Step 5

Once this has been accomplished, the next step is to review all the suggested answers. We have found it helpful to talk about the poor answers first, because as the staff discusses why a particular response is not a good choice, they are often pointed toward the best answer. After hearing everyone's suggestion, we then pick what we feel to be the best response to the particular question and write it down. We also list two or three of the less desirable responses to each question as a reminder not to use them.

### Step 6

The list is now retyped with the answers provided and distributed once more to the staff and reviewed for emphasis. These steps are summarized in Table 1.

Let's look at a specific example. A patient presents at our reception desk and says, "My eye is red. Can I see the eye doctor?" Our clinic has a triage protocol for dealing with such situations. If the patient is currently followed in the eye clinic, the corpsman takes a brief history, obtains the record, and relays it immediately to the treating physician. If the patient is not currently followed in the eye clinic, he or she is referred to the hospital emergency room or acute care clinic for primary care. Now, given this basic triage plan, there are still many possible responses which could be made to the patient, but only one best answer. Let's examine some of the bad answers first.

**Bad Answer #1.** "No. You have to go to the emergency room or acute care." This answer is essentially correct but conveys an unsympathetic attitude and lets the patient know that you are only minimally interested in his/her problem.

**Bad Answer #2.** "No, you have to have a consult to be seen in this clinic." This is also a poor choice for several reasons. It implies that the acute care clinic or the emergency room will give the patient a consult to come back and be seen in the eye clinic. In fact, the majority of eye infections are relatively simple episodes of conjunctivitis which are easily handled by a primary care physician, so

**Table 1. Patient Encounter Skills Development Summary**

1. Outline problem
2. List the questions
3. Compile the lists
4. Develop responses
5. Review responses
6. Distribute best responses
7. Periodic refresher and update

the patient may not need to be referred back to be seen by a specialist. In addition, if the patient is already followed in the eye clinic, then she does not need to have a consult to see her doctor.

**Bad Answer #3.** "No, you have to have an appointment." This answer is incorrect because emergency patients are seen without appointments.

**Bad Answer #4.** "Your eye doesn't look all that bad to me." An exceptionally bad choice because in this situation the corpsman is making a diagnostic decision which he or she is not qualified to make.

**Bad Answer #5.** "Yes, wait right here and let me call the doctor." This response is a poor one because it ignores the established triage protocol.

**Bad Answer #6.** "We don't see retirees." This is an undesirable answer for the reasons enumerated previously.

So much for the bad answers. What should the response to this patient be? If the patient is not currently followed in our clinic, the most appropriate answer should probably go something like this: "Mr. Nelson, what we are going to ask you to do is go to our emergency room. Most eye problems can be taken care of by our primary care doctor there. If they feel that you need to be seen by an ophthalmologist, they will arrange a consultation for you and we will be happy to see you. Can I help you with directions to the emergency room?"

In addition to ensuring that the correct information is being conveyed, working through these various responses also provides an opportunity to go over basic communication skills such as responding quickly and cheerfully to the patient's presence at the front desk, listening attentively to the patient's problem, using the patient's name in one's response, and remembering to add "please" and "thank you" where appropriate. Simple things, but they help to create the friendly, consumer-oriented atmosphere that we all appreciate.

Front desk personnel are also reminded of the fact that they are empowered to use their judgment to handle situations which may require special treatment. An example of such a situation may be found in the procedure for dealing with late patients. Our policy is that a patient who is more than 15 minutes late for his or her appointment is requested to reschedule the appointment on another day to prevent inconveniencing all the other patients on the schedule who would be subsequently delayed if the late patient is seen before them. In certain situations, however, it's important for the front desk personnel to realize that they need to make exceptions, such as in the case of patients who have driven 60 or 70 miles for their appointment or a disabled patient who obviously has great difficulty getting around and for whom a rescheduled appointment would be a great hardship.

Other techniques for dealing with difficult problems may also be discussed, such as the situation where a very difficult patient is encountered at the window or the phone and the patient and the corpsman find themselves becoming frustrated in an attempt to arrive at a resolution to the problem. In this situation it is most appropriate to get up and get another staff person or the clinic leading petty officer to take over the conversation so that tempers do not become short.

Following the initial Patient Encounter Skills Development training, refresher training is held approximately quarterly and the questions are reviewed to ensure that we haven't come up with a better response in the meantime. We also update the list with new questions or situations that have been encountered in the interim. Refresher training is also important because it provides a periodic reminder of our commitment to public relations as well as to quality medicine.

How well do these methods work? We began using these techniques in our clinic last year. Prior to our initiation of Patient Encounter Skills Development training, we were receiving approximately 5-10 complaints concerning rude or discourteous behavior involving clinic personnel each year. For over 18 months now, we have had no complaints regarding rude or discourteous behavior. Informal feedback from our patients has been very favorable. Our Patient Satisfaction Surveys for the past 6 months have shown a 100 percent "excellent" rating by patients evaluating the care that they have received. The increased confidence in dealing with patient problems is obvious in our clinic staff. They now know they are saying the right thing and take great pride in knowing that they are providing service which keeps our patients as happy as possible.

Patient Encounter Skills Development training doesn't take any money and it doesn't take much time. It is a definite morale builder for the staff to share the experiences they have had with patients and try to come up with graceful ways to handle all these difficult situations. As the clinic laughs at how bad some of the poor responses are, it's chilling to realize that almost all these responses have been used at some time in the past. Patient Encounter Skills Development is the single most effective method we have found to ensure that patients leave the clinic convinced that Navy medicine has provided the very best health care possible. ❑

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