

Forum

What Makes for a Compassionate Patient-Caregiver Relationship?

Darshak M. Sanghavi, M.D.

"I was told over the telephone at work that I had breast cancer. I started to cry."—Schwartz Center Rounds, Overlook Hospital, Summit, New Jersey, July 18, 2005

Many patients find themselves at the mercy of an increasingly complex and frequently depersonalized medical system. Vulnerable and often bewildered, these patients depend on medical professionals for not only their purely medical needs but also their emotional, social, and spiritual ones.

According to a 2004 survey sponsored by the Kaiser Family Foundation and Harvard School of Public Health, 55% of Americans are "currently dissatisfied with the quality of health care in this country."¹ What is lacking, many patients may believe, is compassion.

Along with enhancing satisfaction, compassionate care has clinical therapeutic benefits. Physicians with a good bedside manner are more effective,² obtain better information about patients' symptoms and concerns,³ and create treatment plans that better enhance patient recovery.⁴

However, measures of quality are almost exclusively devoted to technical procedures. One observer notes, "By ordering the pertinent technical procedures, a health care system, institution, or clinician can get excellent ratings for 'quality of care,' despite gross violations of human caring."⁵(p. 472)

How, then, should genuine caring be encouraged in the patient-caregiver relationship? Before his death from cancer in 1995, Boston attorney Kenneth Schwartz established a center with the mission "to support and advance compassionate health care in which caregivers, patients and their families relate to one another." The largest program of The Kenneth B. Schwartz Center, a nonprofit

Article-at-a-Glance

Background: During Summer 2005, the Kenneth B. Schwartz Center asked hospitals to hold rounds to discuss the topic, "What Makes for a Compassionate Patient-Caregiver Relationship?" Review of questionnaires and transcripts of the rounds held at 54 hospitals in 21 states yielded three major categories: communication, common ground, and respect for individuality.

Communication: Suggestions to improve compassionate care often focused on style and content. Rounds attendees felt that compassionate care also depends on imparting medical facts in a clear and useful manner to patients—often difficult for complex medical issues.

Common Ground: Compassionate care depends on showing empathy for a patient's illness experience no matter what his or her background. Rounds participants felt that caregivers could make a conscious choice to care deeply for patients. Sharing personal information with patients and admitting mistakes were key methods for identifying common ground.

Treating the Patient as an Individual: Compassionate care requires striking an individualized balance between providing guidance and allowing autonomy to achieve shared consensus, especially with complex information.

A Prescription for Change: Most interventions target students yet do not continually reinforce compassion. Advocates for compassionate care should instead treat lack of compassion not as an acute trauma but as a chronic condition requiring a lifetime of continuous support, regular guidance, repeated reinforcement, specific targeted outcomes, and more innovative care programs.

organization housed at Massachusetts General Hospital, is monthly one-hour rounds, where caregivers from diverse disciplines discuss difficult emotional and social issues arising from patient care. In these rounds, conducted by 80 hospitals in 21 states, a group of multidisciplinary caregivers is convened to address and explore difficult social-emotional issues that arise in caring for patients.

A "National Conversation"

During Summer 2005, to commemorate its 10th anniversary, the Kenneth B. Schwartz Center asked hospitals to hold rounds to discuss the same topic, "What Makes for a Compassionate Patient-Caregiver Relationship?" Each facilitator was asked to guide the group discussion and distill practical suggestions for building compassionate patient-caregiver relationships. The discussion format was left to the individual hospital, but suggestions were made for a panel of patients and/or family members, a panel of caregivers, or a focused discussion of the topic.

Review (by the author) of questionnaires and transcripts of the rounds, which were held at 54 hospitals in 21 states, yielded strong common themes. Suggestions were collected and organized into three major categories: communication, common ground, and respect for individuality. In this article, the narrative findings and supporting literature are reviewed, and a paradigm to improve compassionate care is presented. Findings from this series of rounds were also presented by the author at the Center's 10th Anniversary Symposium on November 3, 2005 (Sidebar 1, right and pages 285–286).

Communication

"One of my doctors here has a sign by his door that says, Did you ask all your questions? That sign sends me the message that he isn't irritated by questions."—Schwartz Center Rounds, Moffitt Cancer Center, Florida, Jul. 12, 2005

The most frequently cited suggestions to improve compassionate care focused on the style and content of communication.

Style

Variably referring to "body language" or "nonverbal cues," rounds participants recommended introducing

Sidebar 1. Symposium Report

2005 Kenneth B. Schwartz Center's 10th Anniversary Symposium: "Beyond the White Coat and the Johnny: What Makes for a Compassionate Patient-Caregiver Relationship?"

The Kenneth B. Schwartz Center's 10th Anniversary Symposium, "Beyond the White Coat and the Johnny: What Makes for a Compassionate Patient-Caregiver Relationship?" was held on November 3, 2005, in Boston before a diverse audience of 200 professionals and laypeople. At the symposium Darshak Sanghavi, M.D., presented his findings from a "national conversation" on compassionate health care.

In addressing the question of why compassionate care is important, Dr. Sanghavi explained the "curious gap between accomplishments of medical science and the public perception of medical care." Although health status indicators suggest that we are healthier now than we have ever been, studies such as those sponsored by the Kaiser Family Foundation and Harvard School of Public Health indicate that the majority of patients in the United States are dissatisfied with their health care. Sanghavi quoted Drew Altman, president of the Kaiser Family Foundation, by attributing this to the fact that "when they talk about the quality of care, patients mean something entirely different than what the experts do."*

In his presentation, Dr. Sanghavi uncovered three major categories of caregiver behavior that influence a patient's health care experience—*communication, common ground, and respect for individuality*. Dr. Sanghavi provided a detailed review of how a care-giver's style, body language, vocal tone, level of sensitivity, and use of complex medical information or slang can affect a patient's perception of the quality of care received.

Illustrating this point, Dr. Sanghavi described how, "one rounds attendee who was a childhood cancer survivor herself remembers a very painful procedure and the caregiver saying 'don't worry, this doesn't hurt' when she knew it would. To her that invalidation was profoundly alienating, even decades later."

In addition, Dr. Sanghavi showed how consideration for a patient's individual needs, as demonstrated

* Carey B.: In the hospital, a degrading shift from person to patient. *New York Times*, Aug. 16, 2005, p. A7.

Sidebar 1. Symposium Report (*continued*)

through small acts of kindness or shared medical decision making, among other methods, can significantly improve the overall patient-caregiver relationship. This was evidenced in the story as told by a physician participating in rounds who has cancer; he recalled panicking while undergoing an MRI. The physician said, "the most important part of that care was a technologist who actually took the time" to hold his hand, something which he felt he didn't need prior to that moment.

The symposium continued with a panel discussion to further explore Dr. Sanghavi's findings, facilitated by veteran journalist John Hockenberry, a former correspondent for *Dateline NBC*. Hockenberry, who became a paraplegic following an automobile accident 30 years ago, shared his personal encounters with the health care world, attributing his positive experiences to his 15-year relationship with a general practitioner. Hockenberry described his physician as someone "who knows me, who knows my history, who knows not only my blood work but who saw the latest story I did on television."

Hockenberry then directed questions to the five-member panel of patients and caregivers, who applied Dr. Sanghavi's findings to their personal and professional lives. Panelist Jacci Goforth, a breast cancer survivor who had served on the Summer 2005 rounds panel at Overlook Hospital in Summit, New Jersey, talked about her initially negative experience with her surgeon, who informed her of her diagnosis over the telephone while she was at work. Prepared to fire this doctor at their first in-person meeting postdiagnosis, Goforth had a change of heart when the physician was able to effectively *communicate* in terms Goforth could understand and accept: "She drew a diagram of the cancer, and where it was, and named everything and it was wonderful. And that's what got me to stay with her...I was just so happy with the diagram and being able to understand it and being able to use that to relay information to my family so they didn't think I was going to die."

Panelist Kathleen Kluger, who participated in the Summer 2005 rounds at Mt. Auburn Hospital in Cambridge, Massachusetts, reported how she, too, was able to turn her initially negative experience with the health care system into a more collaborative and productive one because of a compassionate caregiver. Two

years' experience of devastating physical symptoms and multiple hospitalizations with no concrete medical explanation took a toll on Kluger's emotional state. When she was finally diagnosed in 1975 with myasthenia gravis, a rare neuromuscular disease, Kluger's physician created *common ground* by empowering her with information, answers, and support. Her physician took her to the hospital's medical library, laid out all of the information that was available, encouraged her to write down all of her questions, and made himself available for answers. Kluger recalls, "I wasn't made to feel stupid and I wasn't made to feel like 'I'm the doctor and you're not'...the way he had of introducing me to that (disease)...was just the right thing at the right time."

Hockenberry emphasized the importance of these positive interchanges between patient and physician: "There is a redeeming quality to a single act of compassionate kindness that is very powerful."

Echoing these panelists' sentiments, panelist Thomas Lynch, Jr., M.D, director of thoracic oncology at Massachusetts General Hospital and a Schwartz Center founding board member, stressed the importance of staying in the moment with each and every patient: "I think one of the key things is to try to make a connection with the patient on whatever level you can...I try to find some common bond."

To show *respect for the individuality* of his patients, Dr. Lynch asks each patient how much information he or she wants to receive so he can adequately communicate test results or diagnosis in a style that is comfortable for the patient. "I tend to say, 'listen, there are some patients who like to know all the gory details, statistics, and curves, and there are some patients who like just the broad brushes of what this disease might mean. Where do you fall in that group?'" Lynch explained that although he often ends up giving the same information, he does it in a style that works best for each patient.

Through the stories shared, it was evident that panelists recognized the value of Dr. Sanghavi's new paradigm; focusing on compassion in a systemic manner adds value to the health care experience of both patients and caregivers. Dr. Sanghavi's "prescription"

continued

Sidebar 1. Symposium Report (continued)

for change includes continuous support, guidance, and reinforcement for caregivers, as well as having specific targeted outcomes and more innovative care models.

Dr. Sanghavi acknowledged that, although many of the interventions focus on the health care personnel, we must also "educate patients to best take advantage of the health care system in a way that meets their needs."

Panelist Marion Longo, M.S., R.N., a psychiatric clinical nurse specialist at Beth Israel Deaconess Medical Center in Boston, talked about how forums such as the Schwartz Center Rounds enable provision of information and support among professionals from different disciplines. According to Longo, "you have to have an opportunity and a place where people can really talk about how they feel, what they do, what they feel good about...rather than going home at the end of the day and not being able to remember what you did because you are so tired and there were so many people that you saw." This point was illustrated when a symposium participant who works with critically ill patients described a terrible day at work, during which one of her patients bled to death all over her. Still haunted by the previous day's occurrence, this caregiver began her next day at work feeling emotionally and physically drained. One of her colleagues approached her and stated "I am so glad that you were with Eric* because I know that you would have been calm and that when he looked at you it would have been easier for him." According to the symposium participant, this support from a colleague "turned the experience around for me almost immediately, absolutely immediately." Her story evidences that compassionate support from a colleague helps professionals maintain their level of compassion for patients.

Hockenberry then challenged Dr. Sanghavi to put his own research into practice in an on-the-spot role-play in which he would present bad news about test results to panelist Kluger. Dr. Sanghavi prepared his patient for the information and provided an opportunity for discussion: "I see you are back today. We can talk about some test results...do you have any thoughts before we go

ahead and talk about them?" When his "patient" responded by informing him that "it's just been a very, very, very long week and I have been worried about everything from tonsillitis to the flu," Dr. Sanghavi continued, "Well, that is why I thought it was worth talking in person and have you come back in...the information we got suggests there was something, and I wanted to talk about what that was."

Following the role-play, Hockenberry questioned Dr. Sanghavi's use of the preamble with his patient, noting that although it may have been hard to improvise fictitious test results, was this level of preparation necessary? Kluger responded by asserting, "a preamble that is a preparation to maybe hearing something I don't want to hear goes a lot better than, 'oh, by the way, that nice life you thought you are having, you aren't having anymore.'" Goforth, however, felt that Dr. Sanghavi needed to provide the information in a more timely fashion: "I am OK. I am waiting for you. I have been waiting for a week, so let's get on with it."

This critique of Dr. Sanghavi's performance indicates how even the most experienced clinician armed with the best knowledge and strategies may not always deliver a flawless performance in the midst of a difficult patient-caregiver moment. Dr. Sanghavi attributes some of the discomfort that caregivers have in dealing honestly with patients to their training, recalling medical school as a place where "uncertainty is not tolerated. Not knowing something on the fly is very bad." He believes these messages translate to the way in which caregivers deal with patients. According to Dr. Sanghavi, "the biggest flaw is to say 'I don't know' or 'Let me take a minute to look it up' or 'why don't we take a little time to think about it?' Patients realize that if you admit uncertainty or give them the tools to deal with uncertainty that would be accepted very well, yet we are not trained to do that."

However, although patients may not expect perfection from their caregivers, as Kluger stated at the conclusion of the symposium, "from any caregiver a look, a touch, a joke, an acknowledgement that maybe you're not having such a great day either, that momentary connection, whether it's just visual or just fleeting, it makes all the difference."

* The name has been changed for patient confidentiality.

oneself when entering a room, sitting instead of standing when speaking with patients, making eye contact, and paying careful attention to remembering patient names. Just as smiling can improve mood,⁶ purposeful but simple nonverbal changes in physical style can improve patient comfort. Rounds suggestions support studies showing that patients find sitting caregivers significantly more compassionate than standing ones (even when they aren't consciously aware of the reason),⁷ prefer physicians with uncrossed arms, frequent head nodding,⁸ and a posture of leaning forward toward the patient.⁹

Tone and cadence of speech is critical. For example, one psychologist has found that patients hearing audiotapes of surgeons can easily tell who was sued by angry patients—even after listening for only 40 seconds and even more astoundingly, to intentionally muffled recordings where the actual words were unrecognizable.¹⁰ Similarly, another researcher found that sued physicians did not differ in the content of medical information but were simply less likely to joke, make responsive comments, and “orient” patients by telling them what to expect.¹¹

Interestingly, female caregivers' communication styles generally achieve greater satisfaction than those of male caregivers.¹² Rounds participants repeatedly emphasized the importance of “showing emotion,” or empathy, in response to patient statements, such as “I'm scared.” Studies demonstrate that caregivers dismiss “empathic clues” from patients from 70% to 80% percent of the time—these are missed opportunities to show compassion by responding to a patient's stated anxiety.¹³ Open-ended communication styles may help caregivers recognize these moments more effectively.

Rounds participants regularly used humor to enhance comfort. One patient remembered the following exchange: “My doctor said, ‘I believe in miracles’. And I said, ‘So what you're saying is it would really take a miracle to keep me alive?’ And then we joked about that.” Others emphasized the importance of respecting occasional silence, avoiding interrupting patients when they were speaking, and avoiding rapid-fire question and answer interviews.

Content

Rounds attendees felt that compassionate care also depends on imparting medical facts in a manner that is

clear and useful to patients. This is particularly difficult for complex medical issues. Expressing the ambivalence that some feel, one patient with cancer commented, “Do I really want to know all the statistics? Do I really want to know what my probabilities are? I'm not sure I want to know it.”

However, doctors typically spend less than 60 seconds in a typical visit to talk about treatment options.¹⁴ Patients' ability to process probabilities and data varies greatly, and many patients cannot recall the discussion accurately following a visit. In one telling study, only one patient of 71 patients receiving standardized information accurately recalled the risks of carotid endarterectomy.¹⁵

Rounds participants emphasized that written materials, such as diagrams, printed materials, Web site referrals, along with a mechanism to answer further questions that a patient might leave, alleviated patient concerns.

Other participants cautioned about the alienating nature of certain medical slang, especially when patients were described in formal documentation as “failing therapy,” which appears to assign blame, or referred to by their medical problem rather than their name, since for example, “nobody wanted to be known as ‘the leg in the room’.”

Rounds attendees emphasized that patient morale improved when caregivers appeared highly competent. Attendees also highlighted the importance of good communication among members of the medical team.

Physicians frequently lag in reviewing test results,¹⁶ and participants felt that biopsies and other critical data should be reported to patients as quickly as possible. One person remembered waiting almost two weeks for a colon biopsy result.

Common Ground

“I played tennis with my oncologist, who is very competitive about his game. I was touched when I noticed he was giving away calls in my favor.”—Schwartz Center Rounds, Dana Farber Cancer Institute, Jul. 22, 2005

Rounds attendees frequently cited the importance of a caregiver-patient “partnership.” This trust originates from two kinds of familiarity: unchangeable (“fixed”) and voluntary (“controllable”) ones.

Fixed Factors

Some participants felt that doctors and patients had better connections when they came from the same ethnic group, class, or geographic area. These common social origins may help alleviate some patients' anxiety. One participant, an African-American woman with breast cancer, was initially very worried that members of minorities receive inferior medical care. Research demonstrates that patients who perceive racism in health care are twice as likely to be satisfied with a physician of their own race, instead of another race.¹⁷ However, rounds attendees also felt that other factors were important. For example, only one in five African-Americans, one in three Latinos, and one in 10 whites report preferring a caregiver of their own race. Rounds participants believed that compassionate care isn't restricted to others who physically or socially resemble the caregiver; rather, compassion depends on showing empathy for a patient's illness experience no matter what his or her background.

Others commented that certain clinicians are simply very compassionate by nature. These statements recall a 2005 study of persons who selflessly risked personal harm to help Jews escape the Holocaust in Nazi Germany. A history of friendships with Jews, involvement in social charities, and type of family upbringing didn't clearly distinguish rescuers from bystanders. Instead, the best predictor of compassionate behavior was having "altruistic personality characteristics."¹⁸ Emotionally gifted individuals may be rare; in the Holocaust study, fewer than one-half of 1% of able people engaged in any kind of rescue activity.

Several caregivers reported that personal or family health problems (one rounds participant, a surgeon, recalled having a kidney stone treated at an emergency room) triggered greater understanding of their own patients' experiences. One attendee commented, "The best way to be a good doctor is be a patient every now and then."

Controllable Factors

Although some kinds of extraordinary compassion may be innate, rounds participants still felt that caregivers could make a conscious choice to care deeply for patients. Literally meaning "to suffer with," compassion

requires that caregivers must be willing to take emotional risks. Rounds participants agreed that it was important for caregivers to show honest emotion to patients (for example by crying, which can be seen positively by patients¹⁹).

Many attendees commented that sharing personal information with patients was a key method for identifying common ground. They are not alone; 17% of clinicians disclose personal information to patients during primary care visits, and those disclosures were very rarely considered excessively intimate or otherwise inappropriate.²⁰ Rounds attendees also asserted that physical contact, by offering comfort through touch, was often important to patients.

Patients desperately need caregivers to validate their emotions. One rounds attendee, a childhood-cancer survivor, remembered a painful procedure and being told, "Don't cry, this doesn't hurt." To her, this invalidation was profoundly alienating, even decades later. On the other hand, a physician with cancer recalled panicking inside an MRI scanner. In his case, however, a technician held his hand throughout the half-hour scan to reassure him. He still feels grateful years later. Patients also want validation of their spiritual and cultural beliefs. One rounds attendee, a Jehovah's Witness with lymphoma, was refused care by physicians who did not respect her desire to avoid blood transfusion. She recalled, "When you have cancer and you are fighting for your life, the last thing you want to do is fight with your doctor. I was told I was going to die and they tried to force blood on me."

Once trusted, caregivers can help patients retain hope—a key element for coping with serious illness. In this manner, caregivers can give "recommendations in light of what the physician knows about the patient's values, medical situation, goals, and fears."²¹ Such recommendations include always allowing for the possibility of a cure (while being realistic about the prognosis), having hope for the future (by focusing on attainable goals, such as a day without pain), and assuring patients they will never be abandoned or forgotten.²² One attendee ends all her discussions with newly diagnosed cancer patients by saying, "You will never be alone."

Finally, maintaining common ground or trust requires admitting mistakes. One rounds attendee who suffered from a major medical error after a bone marrow transplant

appreciated a prompt and honest apology—and did not pursue litigation. This openness has financial as well as emotional benefits; hospitals allowing honest apologies have two- to threefold-lower malpractices costs.²³

Treating the Patient as an Individual

“When nothing else medically could be done for the baby, I asked the mom what I could do to help. She said she wanted something but didn’t think I could do it. She wanted to wrap the dying baby in a special blanket her grandmother had made. So I went back to the hotel room to get the blanket.”—Schwartz Center Rounds, Children’s Hospital, Boston, Jul. 26, 2005

Although high-quality medical care frequently requires treating patients with standardized processes, compassion often emerges when patients are respected as unique individuals.

Small Acts of Kindness

Participants attached powerful importance to times when a caregiver took the time to warm a blanket for a patient, remembered a patient’s birthday and baked a cake, or asked simply, “How was your night?” when entering a patient’s room in the morning. A key facilitator for these demonstrations of “generosity of spirit” was spending sufficient time in an unhurried manner with patients. As might be suspected, these statements confirm extensive data about another type of relationship requiring compassion—successful marriage.

One psychologist, for example, has identified behaviors that allow 91%-accurate predictions of whether a couple will remain married or divorce—by listening to a five-minute excerpt of their conversation.²⁴ A key determinant of successful marriage is frequent, brief moments of connection. The importance of small courtesies may be even greater in medical settings. As one patient said at the rounds, “When you say and do something, even if it’s not about the patient, the patient thinks it is because you are 100% of our experience, even though we are only a tiny part of your day.”

Adequate Time

Rounds participants agreed that treating patients as individuals requires significant time commitments.

Higher practice volume correlates with increasing patient complaints and malpractice risks from upset patients.²⁵ The importance of time in forming compassionate care recapitulates the findings of a classic 1973 Princeton University experiment,²⁶ in which the behavior of student seminarians on their way to give sermons about the parable of the Good Samaritan was studied. The researchers hired a man to pretend that he was injured and in need of help to lay himself in a seminarian’s path. No personality traits (based on a questionnaire) predicted if the student would stop to help; the only significant factor was whether the seminarian was told that he was running late.

Increasing emphasis is placed on standardized care; for example, many health care organizations implement clinical practice guidelines, according to which clinicians must collect patient information in specific templates and follow predetermined treatment algorithms. Guidelines, often perceived as “recipes,” may greatly improve the technical care of patients but at the cost of less personal contact and flexibility. Rounds participants recalled several meaningful encounters that could not be included in any algorithm. The turning point in one patient’s sense of control over her own medical care, for example, occurred when her doctor pushed her wheelchair to the library, where he had a stack of all of the journals and articles related to her complex condition stacked on a table—and exhorted her to “learn everything you can about your situation.” In another, one caregiver said a patient only opened up for conversation after the patient was “taken outside for a cigarette.”

Rounds participants emphasized the importance of hobbies and time outside of the workplace to fight “compassion fatigue.” In one study, physicians with “emotional exhaustion” were eight times more likely to have delivered suboptimal care (for example, “I did not fully discuss treatment options or answer a patient’s questions”).²⁷

Telling Patients’ Stories

Rounds participants recommended several methods for preserving patient individuality; one participant made a special point of asking families of patients with dementia for “memory boxes” full of pictures or other reminders of a patient’s life before the illness. By understanding the

narrative of patients' lives, caregivers may find opportunities to explore a patient's world and develop additional respect for their particular culture or background.

Similarly, other attendees emphasized the importance of communicating the "social history" of patients, such as profession, hobbies, religious background, and other details, among members of the care team. Eliciting this information requires asking atypical questions; one author recommends asking all patients, "What are you famous for?" On rounds, this information (for example, if the patient is a skydiver, a baseball fan) is mentioned along with the admission diagnosis, making a patient "a unique individual with a fascinating hobby."²⁸

Shared Decision Making

As the consumer model has entered health care, patients increasingly must process a great deal of medical information to make complex choices in the service of "informed consent." But as one observer has commented, "many find the job of being a modern patient, with its slog through medical uncertainty, to be lonely, frightening and overwhelming."²⁹(page A7) Rounds participants agreed that compassionate care requires accurately assessing a patient's needs. Patients who are asked to make complex decisions may feel abandoned by their caregivers—particularly when they have unlimited access to complex, often contradictory information via the Internet and other sources.

Thus, compassionate care requires striking an individualized balance between providing guidance and allowing autonomy to achieve shared consensus, especially with complex information. This is especially challenging because, for example, many patients cannot reliably understand percentages (for example, "You have a 10 percent chance of getting breast cancer"³⁰(page 241)), have widely discrepant interpretations of terms such as "rare" and "frequent,"³¹ and are variably tolerant of medical uncertainty.

A Prescription for Change

How can the lessons of the national conversation improve the existing system of medical care, which so many patients find lacking? In the past, improving the quality of medical care meant focusing on three areas: racial and geographic disparities, patient safety, and adherence to clinical guidelines—but not compassion.

The Current Strategy

Most interventions to improve compassion primarily target students. Several short-term proposals to teach the importance of compassion among medical trainees have been advanced, including an eight-session "music-in-medicine" course,³² and keeping a journal of "personal illness narratives."³³ These kinds of interventions themselves follow a traditional medical paradigm. The diagnosis, a lack of compassion, is made. A simple cure, preferably one dispensed in discrete, inexpensive, and painless doses (like a few classroom sessions) is prescribed and dutifully taken. The subject then leaves the organization, with no specific plan for follow-up care or assessment.

What's missing is a method to continually reinforce compassion. Permanently changing human behavior—whether to eat healthier or to practice more compassionate medical care—can't be accomplished by the traditional medical paradigm of rapid diagnosis and short-time treatment.

A New Paradigm

Advocates for compassionate care should instead adopt an altogether different strategy—treating lack of compassion not as an acute trauma but as a chronic condition (such as, say, diabetes or severe asthma) requiring a lifetime of continuous support, regular guidance, repeated reinforcement, specific targeted outcomes, and more innovative care programs. First, advocates for compassionate medical care should sponsor regular meetings of small networks of interested people—essentially, support groups—that are part of a larger movement. Describing megachurch founder Rick Warren's "cellular model" for establishing group identity and purpose, Malcolm Gladwell writes in *The New Yorker*:

Membership in a small group is a better predictor of whether people volunteer or give money than how often they attend church, whether they pray, whether they've had a deep religious experience, or whether they were raised in a Christian home. Social action is not a consequence of belief, in other words. I don't give because I believe in religious charity. I give because I belong to a social structure that enforces an ethic of giving.³⁴(pages 62-63)

For example, the Schwartz Center Rounds serve a similar purpose by "enforcing an ethic of giving," with

regular discussion and promotion of compassionate care in many small groups. The act of attending rounds regularly focuses caregivers' attention on the need for compassion.

Second, therapeutic leaders must model behavior for younger health professionals. Unfortunately, teaching at the patient's "bedside" has decreased from 75% to 16% of all medical teaching since the 1960s, so practical knowledge may be harder to obtain.³⁵ Caregivers internalize the behaviors around them, which far outweigh classroom-based lessons. This so-called "hidden curriculum" of medicine is arguably the most important influence on a caregiver's behavior. Good mentoring has clear benefits for both teachers and students.³⁶ Organizations' tacit messages are also formative because "a medical center that gives important leadership roles predominantly to individuals who do not espouse...humanistic care may lead students to conclude that these functions...are less valued than biomedical knowledge."³⁷(page 1068)

Third, clinicians require regular teaching and reinforcement of compassionate behavior—not just in training but also throughout their careers. In 2004, the Institute of Medicine published a sweeping criticism of behavioral and social science curricula in medical schools.³⁸ Probably the best model curriculum is the Kalamazoo Consensus Statement,³⁹ the basis for communication competency exams required by several medical boards. Professional licensing should require continuing medical education related to skills for compassionate care.

Fourth, there must be a targeted outcome, which is a complex but necessary proposition. Calls for accountability currently involve financial rewards, such as tiered reimbursement scales, depending on certain predetermined benchmarks. However, at this point rigorous studies have not been able to demonstrate systematic performance improvement generated by

financial incentives.⁴⁰ Because compassion is difficult to measure, it is not likely to be highlighted in a pay for performance contract.

A second proposal for accountability is "market-driven health care," where patients choose caregivers based on publicly available data on their quality. Yet fewer than 1% of patients use such freely available data,⁴¹ perhaps because current measures assess very limited outcomes (such as time to antibiotic administration for pneumonia) not relevant to most patients.

Although compassionate care itself cannot be quantified meaningfully (it is difficult, for example, to measure "small acts of kindness"), the consequences of such care can be measured. Health plans or insurers can prospectively track patient satisfaction, health knowledge, and health outcomes in terms understandable to patients. Health plans should allow public access to online reviews of physicians from their patients, to harness the distributed intelligence of patients.

Fifth, health organizations must recognize that traditional structure of delivering patient care may be inadequate. Brief, occasional outpatient visits impose several constraints that make individual needs hard to meet. Caregivers should explore more innovative ways of delivering care, such as group visits, daylong retreats or camps for those with chronic conditions (widely used for pediatric oncology, HIV, and asthma), and self-management training (effective in arthritis⁴²). ■

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