

**Stories of Reaching Out:
Building Relationships and Trust**

By Judith A. Greenfield, PhD, RN

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Many of us have stories about interactions with doctors or nurses or patients. Sometimes these accounts paint pictures of mutually respectful clinician-patient relationships, and sometimes not. But not all interactions that start on the wrong foot need end that way. Sometimes those marked by dissatisfaction can serve as opportunities to build bridges. Because we often learn from our experiences, and from the experiences of others as well, this article presents actual accounts -- of a patient, a physician, and a nurse -- where "reaching out" led to stronger relationships and the building of trust.

A Patient's Story: Delayed Diagnosis The symptoms "JS" experienced were diagnosed, by her family physician, as stress-related, pre-ulcerous gastritis. The "wonder drug" he prescribed -- a drug noted for its effectiveness with such conditions -- provided no relief. Her symptoms increased in intensity, duration, and frequency. An x-ray of her gall bladder did show a thin line of tiny stones, but neither her primary doctor nor the gastroenterologist considered that to be the source of her problem. In their view, the condition was still stress-related.

Months passed and her condition got worse. Her doctors continued, unsuccessfully, to treat her symptoms and to deny to the possibility of some other cause. During this time, JS's primary doctor, with whom she had previously enjoyed a good relationship, dismissed her in a variety of ways. He dismissed her self-knowledge that her body typically responds differently to stress. He implied that she might be a hypochondriac when, based on her own research and reasoning, she repeatedly asked if it might be her gall bladder. And he felt that there was no reason to think her condition was due to anything other than stress -- even though the miracle drug did not work. In fact, he blamed JS for her continued problems when he stated outright, that if she would just let the medication do its job, it would.

Twenty months after the onset of her symptoms, JS underwent gall bladder surgery. Based on more tests, a second specialist had said he thought her gall bladder was the culprit. This was confirmed when the surgeon found that her gall bladder and bile duct were entirely filled with sludge. Her first two doctors had been wrong -- on two counts: about the diagnosis and for not valuing what she had to say.

Although family and friends urged her to leave her primary care doctor, she decided that she wanted to first talk with him and tell him how she felt about his attitude. Then, based on his response, she would decide to either stay or leave. When she finally met with him, she outlined the different things he had done that had disappointed her. At the same time, she made it clear to him that she did not want to automatically leave him, as had been suggested,

because she otherwise respected his skill and knowledge – that it was just this instance that had been unsatisfactory. The outcome? He thanked her for coming to speak with him, he apologized, and she stayed. Clearly, this could have gone another way. Had it, JS would have left to find a new doctor. As it turned out, however, this conversation served to save and strengthen their relationship. Both doctor and patient were winners here.

A Nurse's Story: The Uncooperative Patient¹

Frank was admitted to the hospital for prostate surgery – or so the surgeon and hospital staff thought. You can imagine their surprise when the retired, 84-year old refused to sign the consent form and angrily pushed away the respiratory therapist and lab technician as they approached him for pre-surgical work-ups. Why, then, had Frank come to the hospital, if not for surgery? Well, it seems that Frank had entered the hospital solely to appease his daughter and granddaughter. While he was prepared to stay there for as long they wanted, he was unmovable about surgery. He just wasn't going to have any!

After repeated efforts to change his mind failed, his nurse, Nancy, determined to find out why he was refusing surgery. When she asked what was troubling him about the surgery, and if there was anything he didn't understand, he told her that it was she who didn't understand. He seemed somewhat taken aback when she asked him to tell her what it was that she didn't understand, but he did tell her. It turned out that his reluctance dated back to a work experience of his youth, where his supervisor would assign extremely dangerous jobs to men he didn't like. The men did what they were told because they feared losing their jobs, and a number of them were severely injured. When Nancy responded by saying it seemed as if he did not trust people, he replied: "nope...I don't know if what people's telling me is for my own good or if they wanna get me for some reason you might not even know."

The two continued to talk, with Nancy taking his hand and telling him that the decision was his, but he should know that they were only interested in helping him. She left and shared what she had learned with his surgeon. When she later returned for one last try, she found a smiling Frank who, after just getting off the phone with the surgeon, turned to her for confirmation that the doctor was "...a good gal..." who had "...no reason to hurt me..." and said that he would undergo the surgery. This experience, Nancy reports, made it clear to her that simply listening and showing you care can go a long way to building trust.

¹This is a summary of a first-hand account, reported by Nancy Kirkpatrick, in "Frank Needed More Than Surgery", *Nursing* 31(6): (June 2001).

Doctor's Story: Inconsiderate and Angry Patients²

Stories of doctors "firing" patients are on the rise. Dr. Solomon, a family physician has asked some of his patients to find other doctors. Nevertheless, he has found that talking with them before finalizing the "dismissal" can sometimes lead him to change his mind and, ultimately, lead to the establishment of strong doctor-patient relationships. He describes the two following cases.

The first involved "Candace", a woman who called him in the middle of the night about her daughter's case of head lice. She offered no apology for disturbing his sleep. He was so angry he wrote a discharge letter, but decided to wait and give it to her at the end of her daughter's next appointment, three days later. When the time came, he told her he couldn't understand the need for her call and hadn't been able to get back to sleep for hours afterwards. He said it made him so angry that he didn't know how he could continue to care for her. He asked her to leave his practice and gave her the letter. At this, she grabbed something from a bag and thrust it at him. While crying, she explained that she had called because she had been so distraught at her daughter's persistent discomfort; that she had felt so badly about calling. And because he had been so good to them she had wanted to thank him by knitting him an afghan – the item she had just thrown at him. The end result: they spoke further and worked it out.

The second case involved "Sharon", whose anger at Dr. Solomon for not writing a note that would excuse her son from an exam, led her to say of him, in front of other patients, "I wouldn't take my dog to see this guy...he doesn't know what he's doing." When Dr. Solomon called Sharon to tell her that he felt he could no longer care for her after she said those things in front of other patients, she asked if she could come in and talk with him. He agreed. When she came, she apologized, explaining that she didn't know what came over her and that she wanted to stay. She then went on to describe symptoms of clinical depression and panic disorder. The result: she stayed; he ran some tests and started her on medication that helped.

² This is a summary of first-hand accounts reported by Gil L. Solomon in "When Patients Try to Bully You", *Medical Economics* 75(9): 112 (May 11, 1998).

Some Comments About The Stories

These stories point out mistaken assumptions that the actual clinicians and patients had of one another. They also suggest the importance of getting past those assumptions if relationships and trust are to be achieved. And, as some of them demonstrate, one way to get past general assumptions is to reach out – to try to understand the individual – to ask and to listen.

Readers are also cautioned about assumptions and are urged to refrain from automatically viewing these stories as providing evidence for their own preconceived notions. The delayed diagnosis story is a case in point. Some might chalk it up as yet another mark against doctors. However, the responses of JS' physicians were not entirely without reason. Why? Because her symptoms were not ones typically associated with gall bladder problems; because many people with gall stones never experience symptoms or have the need to remove their gall bladder; and because it has been shown that many patients don't take their medications, (at all or as prescribed), and some even lie about it. For all they knew, this could have been the case with JS. Where they missed the boat, however, was in not trying to explore whether any of this was the case with her – they neither asked nor listened. And JS' primary doctor had let his general assumptions of patients overrule his long-standing knowledge of her. A mistake he would not have been aware of if JS had chosen to find another doctor without speaking to him first.

The Nurse's story of the uncooperative patient highlights essential, yet often forgotten, elements of communication: the simple acts of asking "why?" and really listening to the answer. The message here is that, when both take place, they can serve as first steps to building trust. The doctor's conversations with his patients, although they came about differently, also point out the benefits of talking with one another -- namely, building understandings of why people act as they do. While it may be preferable to begin with the question "why?" the key, it seems, is being open to hearing what others have to say. Similarly, as shown by Dr. Solomon's account of his "firing" of Sharon, patients' who unexpectedly find themselves in that position, might benefit from trying to find out why and, where appropriate, to explain themselves. Difficult as that might be, not doing so guarantees the end of the relationship, while doing so might help both patients and doctors to come to new understandings – to build stronger relationships and trust. □

Judith A. Greenfield is the Contributing Editor of the *Healthcare Communication Review* and the President of the Healthcare Communication Project.