

Changing Behaviors To Build Better Physician/Patient Relationships

A look at 5 ways to motivate people

By Charles E. Dwyer, PhD

HEALTH CARE LITERATURE is bursting with commentary about patient rights, patient expectations, patient demands, patient welfare, patient safety, patient privacy, informed consent and quality of care.

Why are these topics of concern? Why can't we just take it for granted that the patient and the patient's interests come first in the business of health care?

Obviously, we cannot take it for granted. But the reasons why we can't are not too obvious—and neither are the remedies.

It's not all about patients

Descriptively, empirically and demonstrably, the health care system is not all about patient health.

It's not all about patient health any more than the educational system is all about teaching students, or the governmental system is all about providing citizen service, or the correctional system is all about rehabilitating criminals.

All organizations are about power, resources and seekers.

By definition, the resources of any organization will be allocated by, and to, the seekers with the greatest power. Physicians have been losing their traditional role-based power and, understandably, they resist and resent the loss.

Ethics is the study of what ought to be. Power is the determinant of what is.

So an understanding of power, its nature and use seems helpful if we seriously want to improve patient care and physician/patient relationships.

IN THIS ARTICLE

Changing behaviors may be the key to strengthening the physician/patient relationship. Learn what motivates people to act the way they do, and take a look at behavioral changes that could be made to better serve patient values.

Patients hold less power

Historically, and for the foreseeable future, patients hold the least amount of power in the health care system and their values are served last.

Clearly, patients have little control over the quality of their care. That doesn't mean physicians and other health

care professionals do not care about patient welfare.

I suspect that most care deeply.

But what is needed to ensure high-quality care?

Implementing various quality systems isn't going to assure high quality, although they may help. Likewise, an inspiring "vision" or well-grounded philosophy such as ACPE's *Leading Beyond the Bottom Line* could help. And relevant knowledge, understanding, skill and talent are vital in the quest for higher quality. But they are insufficient to ensure it.

An aspect of change that is often neglected is the willingness of the people involved in quality improvement to alter their patterns of behavior. Patient care and the quality of physician/patient relationships are ultimately a function of behavior.

Influencing behavior

There is a lot of motivational talk about getting "buy-in" and "getting people on board" with organizational objectives. But, in my experience, most of this misses the point.

I believe there are five reasons people behave as they do:

1. Exchange

Much of what we do is done in anticipation of receiving something of value from others, such as money and other resources, acceptance, approval, recognition, praise, gratitude, respect, status, esteem, promotion or fun.

2. Immediate satisfaction

Again, much of what we do is done in anticipation of instant fulfillment—recreation, entertainment, pleasurable experiences, enjoyment, comfort, professional satisfaction, or we simply enjoy doing it.

It is probable that much of what patients experience in the way of quality care comes from "coincidences." Physicians engage in an activity they find immediately satisfying and do it well. As a result, the patient is the "coincidental" recipient of that high quality behavior.

The physician doesn't need to try to benefit the patient or even care deeply about the patient's welfare to provide excellent care. I am confident that an enormous amount of patient value is delivered in this way.

And while I would prefer the altruistic motive behind the behavior, I am content with the behavior itself, whatever the motive.

3. Actualization and validation of the 'good' self

We prefer to think of ourselves as good people. We see ourselves as people who consider the values and welfare of others. We believe we have a strong sense of ethics, morality, prohibition, professionalism, honesty, fairness, justice, compassion, empathy and caring.

So another reason we do something is because we think it's the right thing to do. We do it even though it



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may be risky, even though it offers no personal gain, or even if no one ever knows we did it. Nevertheless, we do it because we think it's right.

An excellent example is the willingness of physicians to lie in the interest of their patients' welfare. A significant percentage of physicians anonymously acknowledge that they falsify records to help their patients qualify for medical reimbursement. Physicians claim their patients' health could suffer if they didn't lie to get certain treatments or procedures.

I regard that as a courageous act. I'm confident that physicians find this activity risky and repugnant. There is no external reward. But they have done the right thing.

4. Long-term investment

Anticipation of a long-term reward drives our behavior as well.

People go on diets and take up exercise programs in anticipation of eventually achieving better health, improved appearance, greater functionality or a longer life. We are willing to make sacrifices in the present, if we perceive a high probability of significant value satisfaction in the future.

We often do things in a long-term quest for security or success—for what we consider "the good life." Physicians consistently use this approach to influence patients.

"If you are willing to put up with the uncomfortable side-effects of

this medication for the next few weeks, your condition will improve markedly." "If you are willing to maintain this painful physical therapy you will recover use of your legs."

But this approach is inept when physicians try it with fellow physicians. They paint a glorious picture of their own vision of a desirable future and assume the vision will inspire others.

We are all interested in the consequences of our behavior for our own values not those of another. We do what we do for *our* reasons, not for the reasons of another and certainly not for the "good of the organization."

5. Loss of value satisfaction

Still another reason we do what we do is to protect value satisfaction.

We willingly engage in difficult, costly, risky and otherwise unappealing behaviors to diminish any threat to our values. Physicians routinely use this approach with patients. "If you don't take this medication regularly, you risk losing your vision."

Fear, coercion and intimidation can be used to influence, but must be used with great caution since people don't like them and develop coping mechanisms to combat them. These mechanisms operate against the person bringing the pressure to bear.

There is another way to look at this fifth reason for behavior.

If physicians think engaging in patient-sensitive behaviors and building more positive relationships with patients risks loss of value satisfaction, they will be reluctant to do it.

I suspect this is the principle deterrent to changing patterns of behavior that would improve patient

care and relationships. It's not a lack of vision, philosophy, knowledge or skill that keeps physicians from the desired behavior. It's the potential costs of such behaviors.

As physicians know better than anyone else, they are under enormous pressure to take financial, legal and moral responsibility for the welfare of their patients. They are expected to do more with less resources, autonomy and authority.

For most of us, altruism is a significant factor in our decision making. But it can only take us so far when faced with mounting demands for sacrifice. "Good of the patient" can be a powerful motivator of physician behavior, but it is not omnipotent.

Do we really want to empower patients?

A useful illustration is the growing call for "patient empowerment."

This is part of a much larger trend allegedly to "empower" people—employees, consumers, taxpayers, etc.

New laws and the Internet focus on empowering the patient, but not necessarily improving patient care. If I were a physician, I would be most cautious when it comes to empowering patients—at least in terms of what I mean by "empowering."

I suspect most people who talk about empowerment actually intend to give others some authorization to make certain decisions in limited areas. But if the recipients do not use that authorization in appropriate ways, it will be taken away.

What I mean by empowerment is giving knowledge, understanding

or skill to others to use in the service of their values. Once given, the knowledge, understanding or skill cannot be taken back. And the recipient may well use them in ways that meet with disapproval from the giver.

For example, you empower people when you teach them to read. The power, once given, cannot be taken back. New readers can use that power as they see fit in the service of their values. And the readers may use the power in ways that don't meet your approval.

It is probably possible to empower patients and improve patient care. But that could disadvantage the physician. I would not expect physicians to eagerly embrace this type of empowerment.

Professor hospitalized, seeks quality care

When I was a patient at the University of Pennsylvania hospital about eight years ago, I wanted the highest quality of health care possible. I believed it was critical to build positive relationships with the health care staff.

I knew I had very little power as a patient. And some caregivers may have reacted negatively because I was a faculty member at the university. I also understood that my personal power held unlimited potential. My patterns of interaction with the staff were key to securing the highest quality care.

Coming out of anesthesia, I felt some pain. But when the nurse walked in, I didn't talk about my needs first, didn't moan and groan, didn't make demands. Instead, I got to know her and what she valued. I called her by name, smiled, and when I noticed a wedding ring asked about her husband. When she mentioned her children, I memorized their names, ages and grade levels in school.

Whenever she came to take care of me, I first talked about what was important to her. I also have collections of jokes, cartoons and sayings about nearly every profession. So when the nurse came to take care of me she would always leave with a joke—usually about a doctor.

The nurse would then go to the nursing station and become the center of attention as she shared the joke with her colleagues. I received exceptionally fine care from the nursing staff. We “bonded.”

In turn, the nurses shared information with me about the hospital and doctors that I suspect they did not share with other patients. My room seemed like a magnet for the nursing staff. On the day of my discharge, nurses came in to tell me how much they were going to miss me.

My effort paid off. I engaged in a simple exchange of value satisfactions—the more high quality health care you give me, the more personal value satisfaction you will receive.

This is merely one example of using power and influence to build positive relationships.

Limited chances for success

But I hold little hope that patients and physicians will make much use of this approach.

- The approach won't work for people who possess a “victim” mentality where they assert their rights and threaten dire consequences for failing to honor those rights.
- Also, people who feel powerless tend to concentrate on the negative approaches to influence.
- At the same time, we have a dependency culture where people expect others to take care of them. They feel “entitled” and think they

should be cared for with little or no effort of their own.

Unless some of these change, I doubt people will develop the strong ego necessary to use the positive approach to building relationships and influencing behavior.

Finally, physicians are embattled.

We have a dependency culture where people expect others to take care of them.

Mergers, acquisitions, divestitures, a turbulent working environment, diminishing power and autonomy, and increased accountability have beaten physicians down.

They are also being cast as the primary societal scapegoat for all the ills of the health care system.

In response, physicians argue that they shouldn't have to build patient relationships, that the system is diminishing their capacity to deliver high quality health care, and that they don't have any time.

Nevertheless, there is a ray of hope.

As numerous previously published articles in this journal have pointed out, you can take control of the quality of your life. External forces need not dictate how you feel and what you do. Increased quality of care and building solid relationships with patients do offer rewards such as:

- Praise or gratitude (exchange) from the patients.
- The immediate satisfaction of doing what you love to do.
- The opportunity to actualize yourself as somebody who truly cares.
- The long-term benefits of offering superior care, such as better outcomes, increased patient satisfaction scores, etc.

All of these rewards are there to be found, but you have to take

active steps to change your patterns of behavior in order to find and create them. ●



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