

Communicating Complex Care  
By  
Staying on the Path of Relationship

Did you ever feel like the patient wasn't listening to you? You were explaining the patient's problems, the cause of the disease and the recommended treatment and you had the distinct feeling that you were talking to the wall. Perhaps the patient had a blank stare or a glazed look in their eyes or they asked the same question again and again. Often this response is seen when the difficulty or complexity of the problems and solutions are increased. The patient often says something like, "Well, Doc, I'm going to have to go home and think about it. I'll get back to you." We may believe that those patients don't value their health or fine dental care. We may feel like we didn't do a good enough job explaining the danger of waiting to treat, that we should have educated them more or that we didn't have a good enough "closure."

During this and ensuing articles we're going to explore the nuances of establishing and maintaining communication with the patient through the case development and treatment discussion process. We'll look at some reasons why the listening can stop and how you can care for your patient better by "staying on the path of communication."

One of my true loves in life is hiking in the high mountains. The other day I was walking up a path amongst the trees and streams sort of day dreaming when down the trail in front of me came a huge dog off leash. He saw me and charged, hackles raised and teeth bared. I was horrified. The master came around the bend yelling at the dog to stop, but the dog wasn't listening. Just as the dog was about to leap at me, he stopped suddenly, slid to a stop and trotted back to sit and stay with his owner. As I approached cautiously, it became obvious that the dog was now under the influence of his master, listening carefully as he was admonished. I asked the man how he had regained the dog's attention. He pulled a case out of his pocket about the size of a garage door opener. It was the sender for an electronic training collar. "When I need to get his attention, sometimes I have to give him a little jolt," was my answer. I thought "cool", wouldn't it be great if everytime the patient wasn't listening I could shock them back into communication? Obviously, we're not going to be fitting our patients with any shock collars. It's bad enough that they are being used on the poor dog. But, in our frustration and sometime feelings of rejection, we may search for a tool to help us earn and hold the patient's attention. We do need to send a signal to the patient. Not a shock or jolt, but the signal that we are more about listening to them than having them listen to us. For many patients, that concept will be shocking indeed.

You see, as the complexity of care increases, as the descriptions of the disease and the treatments are more involved, our traditional model of case discussion diminishes in effectiveness. We are trained to describe the patient's conditions, why they have occurred, why they are threatening, what the treatment is, the risks, alternatives and benefits of care, the cost and the possible sequel of no treatment. This is an important model and critical for all of us to master. However, as the care becomes complex, the patient has greater difficulty staying with us. As that happens, a different model of communication can become beneficial to incorporate in the process. We'll call our traditional model the "educational" model and the adjunctive or complementary model the "leadership" model.

Let's go back to the image of walking on the path in the mountains. When we first meet the complex care patient, we are usually at a low level of relationship. We're just getting to know each other. We learn that they need advanced care that is going to require a high level of trust, communication and cooperation. We're going to have to metaphorically walk up the path of relationship with this person to a high level. There may be forks in the path where we'll need to stay together to reach the top. The "educational" model teaches us to urge, convince, teach the patient why they should come along with us on our path. Certainly, there are conditions that demand that we are very assertive in convincing the patient to treat right away. How often is there a great sense of urgency to complete a full reconstruction? Assuming that the doctor doesn't need the treatment more than the patient, it's not too often. The "leadership" model recognizes that in order to stay in communication, in order to keep the relationship growing, recognizing where the patient's path may separate from ours and staying on it with them may be more effective in eventually reaching the top of the mountain, providing the complex care.

Often my colleagues get nervous when I talk about incorporating an additional model of communication into the case development process. They say, "It's our duty to educate and convince the patient to accept care." Educating our patients is fundamental to what we do and remains ultimately important. What I am talking about is expanding our scope of communication skills so that we can diagnose those forks in the path where we can lose the patient and may have no further opportunity to positively influence them. We diagnose disease and determine what treatment approach we will recommend for individual patients every day. Why can't we learn to diagnose behavioral and communication styles and select the most effective responses to help build our relationship with the patient. Won't they have a better chance of following our advice if they can still hear us?

The leadership model recognizes that our communication style may need to change as the complexity of the case discussion increases. We may have to choose to follow the patient's path in order to maintain the relationship and, within the standard of care, it may be in the patient's best interest to back off of the convincing mode if they're not ready to hear it. Let's look at this adjunctive model.

We call this the leadership model because it follows the basic tenets of leaders. Steven Covey, the author of "The Seven Habits of Effective People", states, "First seek to understand, then to be understood". Commonly, in the traditional model, we understand much about the disease, but little about the patient when we are explaining care. We are often assuming that the patient wants to hear about their conditions, is concerned about them, and is ready and willing to deal with the expense and hassles inherent in the care. Growing the relationship means understanding and honoring the patient's perspective and making no assumptions. Asking simple, honest questions about the patient's interest in pursuing a treatment plan, their ability and willingness to look at a plan for their oral health, and how their life might get in the way of proceeding with care are important tools for staying on their path. When the patient feels understood and has the opportunity to feel that you are truly interested in them as a human being, you have a better chance of them listening to you.

Another important trait of leaders is the ability to give people hope. Napoleon said, "A leader is a purveyor of hope." We can give hope by reassuring people that we understand them. We have heard their concerns, their fears, and the story of how their condition is

affecting their life. When we tell the patient, “I understand how you feel, I have helped many patients who have felt the same way,” they feel reassured that they are in the right place and the relationship grows.

Another important leadership trait is the ability to deal with tough issues honestly and effectively. Often the patient isn’t hearing us because they have loud inner voices. They may be very concerned about their appearance or their budget and be carrying on an inner dialogue that can be very loud. Our description of care may be competing with their unspoken question about “how much is this going to hurt” or “how much is all this going to cost”. Until we speak to that inner voice and quiet it, we may go unheard. Comments like, “I know I can help you. What I don’t know is whether this is a good time for you to fix your mouth. Dentistry can be surprisingly expensive and time intensive. What questions do you have for me” are designed to put the tough issues right out on the table. Demonstrating an openness to discuss the awkward issues early in the relationship can build trust. Being willing to accept the patient’s limitations and support them even if they are not ready for care right away can strengthen the relationship.

Great leaders have the ability to compel people to follow them because they want to. It’s called resonant leadership. We follow people we like and we feel like us, people that we share common ground with and speak our language. It is easy for us to open a gap in our relationship with folks by speaking in technical terms and about all the things we’re going to do to fix things. This is known as a “knowledge” gap. The dentist will be talking about planes of occlusion and vertical dimension instead of a more “secure bite” or “comfortable jaw”. I went to the electronics store to view flat panel tv’s the other day and this 18 year old kid started going off on me about “LED’s”, “DLP’s”, “DPI’s”, “DUI’s”, “BFD’s”. I got so confused that I just wanted to leave. All I had wanted to do was see what picture appealed to me. Have you ever heard, “all I wanted was for this tooth to look better,” or “can’t you just tighten my removable bridge?” We can confuse and overwhelm the patient with our depth of knowledge and lose the case because we opened the “gap”. Speaking simply and humbly is a powerful relational tool that can keep the patient with us.

The leadership model can be more effective in keeping our patient’s listening to us, keep us on the patient’s path because it cuts through the assumptions, deals authentically with the patient’s limitations and allows us to be real people that the patient can relate to. In the next article I will begin to dissect the leadership model into bite sized pieces. We’ll explore some common ways that we separate from the patient’s path. We will learn how to “speak to the inner voice”, avoid the “knowledge” gap, give hope and recognize when we need to allow the relationship to develop more fully before the patient is ready for complete treatment. We can’t “shock collar” the patient, but we can jolt ourselves into the reality that it is our professional responsibility to maintain communication with the patient just as much as it is to deliver the appropriate treatment plan.