The Three-Second Pause

April 8, 2011

Greece Volunteer Ambulance, Inc.

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Training:

- **BDLS**
  PSTF
  April 12
  0730-1600
- **PALS**
  April 16
  April 17
  0900-1700
- **CPR**
  April 20
  1830-2130
- **Practical Skills**
  April 21
  1900-2000

Upcoming Events:

- **GVA Awards Banquet (Lakeshore Country Club)**
  April 9
  1800—2300
- **MLREMS/REMAC (Hamptons Corners)**
  April 18
  1600-1900

"Try to save the lives that can be saved....and accept the ones that you cannot."

Why Being Nice Is Part Of Patient Care

It's 3 a.m. when you are called from a comfortable "resting" position for a 46-year-old male patient with chest pains. Your in-unit GPS and box book direct you to the home, where you find the patient sitting in a recliner, sweaty, pale and clutching his chest. You begin your assessment by saying hello and asking the standard SAMPLE and OPQRST questions. You break out the latest and greatest EKG monitor, which is capable of 12-lead field transmissions, communicate with the physician on an 800 UHF radio for instant orders and consultation, and check your PDA for information on the patient's current medications. You place the patient on a stretcher with friction locks, load him easily into a new truck, and transport him in an air-conditioned box using your superior ACLS skills. Lo and behold, the patient survives. You crank out your PCR on a laptop computer that allows the patient and nurse to sign on the screen, and you're ready for the next call.

What does your patient remember?

Don't Forget the Patient

I've been in EMS for a decade and have seen all manner of cool toys, tricks, technology and tools to help providers give state-of-the-art safe and effective patient care; yet, in all that time, one simple and possibly the most important part of patient care seems to be overlooked: the patient.

There is no gizmo to do a patient assessment, create the patient report or convince the patient you know what you're doing. There is no standardized course that teaches new medics how to convince an elderly patient to open the door or an immigrant mother to hand over her baby to be checked out.

I already hear the dissenters. Who cares if the patient likes me? I'm trained to assess, triage, treat, transport and repeat. This is 9-1-1, not Disneyland. So why is it important?

Hospitals started asking that same question more than 20 years ago and came to realize that patients do care how they're treated. In fact, in the U.S., patients can choose to receive care just about anywhere they want. When hospitals started to realize that to keep the doors open and, more important, maintain a profit (so they can expand their impact on their communities), they had to start treating patients with the compassion and civility they would want for their own families. Today, all hospitals have financial incentive to focus on patient experience. The government recently implemented a system called HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), which requires any facility that receives Medicare/Medicaid dollars to report certain figures openly, publicly and in a standard fashion. One of those key indicators is how patients perceive the quality of their care as measured by a series of questions administered after their hospital stay.

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So why does what happens in a hospital matter to EMS? It's important because no patient, no matter how benign or deathly ill, cares about the hours you've dedicated to studying and continuing your education. They don't care what your IV percentage is, or that you have the latest and greatest technology, and they don't even care that you have the best skills in the business and were voted greatest medic in three states. The patient won't ask to see your credentials, your resume or a list of professional and personal references, and most of the time can't tell the difference between a basic EMT and a paramedic.

He won't care about any of that until he knows how much you care about him. As my first medical control doctor told us at our paramedic graduation, "In EMS you will walk into patients' lives with an assumed trust that they will give their lives to you, look to you for the answers they can no longer find and expect you to make them feel better." Somehow over the years that got translated into making them feel better by using all the great technology out there and hoping they realize they are getting state-of-the-art care.

We deal in perception on a daily basis. We tell psych patients to trust us; we tell the new mother whose child won't stop crying that everything will be OK. It is that perception that we have the opportunity to control and shape. It is our greatest weapon against stress, shock and even cancelled calls. The reason is simple: Perception truly is reality.

Hospitals found that a physician's bedside manner is exponentially important for many reasons, one of the largest being litigation. A physician who is unfriendly, but supremely competent, is much more likely to be sued over one who has excellent bedside manner and is nice to patients. In EMS, being nice to a patient will allow you to stick him more than twice, will make the difference between a calm and cooperative ride versus tying him down, and will even convince a 46-year-old male to go to the hospital.

There is a difference between sympathy and empathy. To be sympathetic, you have to actually know the person and feel what he or she is feeling--have a connection with them. Empathy can be faked, and anyone can do it. Essentially, you are sorry about whatever happened to the person. It really is that simple. You don't have to be sympathetic, but you must be empathetic to all your patients. Like it or not, even if it's the fifth time you've been to this address during the shift, no one calls 9-1-1 because they're having a good time.

So how can you establish rapport and convince the patient you're competent without wasting valuable time on scene? Using key words at key times allows you to deliver a consistent message to all your patients every time. Unlike Hollywood, this is not a word-for-word script that must be memorized, rehearsed and repeated verbatim at every patient interaction. Rather, it is a concept that, if used consistently, will become second nature and convey a clear, confident message of purpose and empathy.

Chances are, experienced providers are already doing this in some way. These are the individuals with the lowest number of cancelled calls; the ones who receive letters and cookies from patients. For those of us not naturally gifted with that kind of public response, I offer the following tool from the Studer Group called AIDET: Acknowledge, Introduction, Duration, Explanation and Thank You:

- **A**cknowledge the patient
- **I**ntroduce yourself and your partner
- inform them of the **D**uration of time (ETA, etc.)
- **E**xplain what you're doing the entire time (especially prior to medication administration, starting an IV, cardioverting, etc.)
- and **T**hank them.

In a cardiac arrest situation, this is a moot point, but it can be a simple addition to your assessment on 90% of the calls. Following is an example of a real call: "Hi. Are you the one we're here to see? What's your name?

OK, Mr. Smith, my name is Jason. I'm a paramedic with Greece and this is Jim, my partner. Tell me how I can help you tonight." Now, continue your normal assessment, asking all pertinent questions, gathering a history--all those things that would make your paramedic instructor grin. "Mr. Smith, what hospital would you like to be transported to? It will take about 20 minutes to get there [actually 15, but underpromise and overdeliver]. While we're moving, I'm going to be doing a few things like starting an IV, which will hurt a little, and I'll give you some medications. I've been doing this for over ten years, and I want you to know we are going to take great care of you. Do you have any questions?" You then explain the IV procedure, the medications you're giving and why (prior to administering them) and answer any questions you can. When you drop the patient off at the ED, thank him. Why? The patient didn't request a specific unit to pick him up; he didn't ask for a paramedic by name. That's not the important thing. You thank him for calling 9-1-1. "Mr. Smith, I want to thank you for calling 9-1-1. I know it wasn't easy, but making that call may have saved your life." We do that to empower patients and make them feel good about accessing a service rather than waiting until much later in the disease process. Because patients are reluctant to call 9-1-1, thanking them is a step in the right direction.

What about the not-so-desirable patients? Thank them too, and treat them with the same respect you would show a friend. You don't have to hug them; just be respectful. I've never met anyone who got into EMS for the money. We got in the business for many, many reasons. One of the key themes I have run into throughout my career is "to make a difference." We must always remember that regardless of how many times a person calls 9-1-1, this is the worst time of his or her life, and every call must be treated that way--every time.