

PART

1

**ESSENTIAL
ELEMENTS OF
PATIENT-CENTERED
CARE**

CHAPTER

1

HUMAN INTERACTIONS AND RELATIONSHIP- CENTERED CARING

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This chapter does the following:

- Explores the role of human caring in creating optimal human interactions in health care environments
- Describes the Relationship-Centered Care/Caring model and how this supports a patient-centered approach to healing partnerships

Note: This chapter draws heavily on two previous works: J. Watson, *Nursing: The Philosophy and Science of Caring* (2nd ed.), Boulder: University Press of Colorado, 2008; and L. Gilpin, "The Importance of Human Interactions," in *Putting Patients First* (1st ed.), San Francisco: Jossey Bass, 2003.

4 Putting Patients First

- Describes tools and techniques employed at Planetree affiliates that foster optimal healing relationships

INTRODUCTION

When Angelica Thieriot, the founder of Planetree, was confronted with an acute illness that required hospitalization, she felt it was more frightening to be hospitalized than to face a life-threatening health crisis. “First do no harm” is the golden rule of health care. Yet many patients leave hospitals, as Thieriot did, feeling abused, traumatized, and dehumanized. In an attempt to alleviate physical suffering, many health care environments seem to create—or at least exacerbate—emotional suffering. Planetree’s goal has always been to change the way patients experience hospitals and other health care settings. This experience is fundamentally rooted in the interactions and relationships between patients, families, and health caregivers.

Clinical care and health care practices are grounded in human communication, human interactions, and relationships. At the same time, approaches to system solutions are often disconnected from relationships and caring. “The current dilemmas in health care are often located within a framework that emphasizes the outer forces of economics, staffing shortages, and technological-medical issues, or system/institutional needs” (Watson, 2004b, p. 249). This disconnection between the current focus in addressing health care issues (read that as *sick care*) conflicts with and greatly differs from the deeply human-to-human caring relationships and human-to-human connections that give meaning and purpose to nurses, patients, all other health practitioners, and systems alike.

In spite of, or because of, the dissonance between and among the diverse external forces affecting health care and the human caring relational dimensions, it becomes mandatory to recognize and acknowledge that any authentic solution to health problems has to arise from a deeply human discourse—a discourse that philosophically and theoretically underpins and guides health and healing for professional-disciplinary practices and system changes. The Planetree model of care provides a framework for shifting the discourse toward more humane and caring practices for practitioners and systems.

Whereas the health care system excels at measuring and improving the “what” and the “why” of medical care, patients themselves are more concerned with the “how” and “by whom.” In a technological era that values the objectivity of science, little regard has been given to the

subjective experience of patients. Subjectivity is often relegated to the realm of *patient satisfaction* and referred to as *soft science*. Although patient satisfaction is viewed as vital to the hospital's financial health, it is rarely perceived as having an effect on the health outcomes of those who receive care. New medications, procedures, and other advances in medical care are often studied extensively, whereas the manner in which these advances are delivered is intentionally factored out. As Leland Kaiser points out, "If it doesn't matter how the care is delivered, why do pharmaceutical companies conduct double-blind studies?" (personal interview, April 11, 2001).

What underlies many of the issues raised in focus groups and satisfaction surveys with patients and caregivers alike is an area that medical science finds difficult to define, much less to quantify. It involves the vague and elusive but vital area of human interactions. How do we communicate caring? How do we ensure that patients feel respected? How do we encourage patients to ask questions? How do we honor patients' dignity when dignity may be defined differently by each patient?

When a nurse or other caregiver enters a patient's room to give a medication, deliver a meal, or complete any task, what really takes place? Medical science would have us believe that completing the task alone is enough. Quality is seen as a measure of how skillfully and efficiently each task is performed. But from the patient's perspective, every task is more than the delivery of medical services. It is an opportunity for a caring human interaction and forms the basis for a healing partnership between patient and caregiver.

These relationships are central to attending to the humane, ethical considerations that affect subjective human experiences, perceptions, and meanings related to hospitalization or treatment regimes (Shattell, 2002). Whether the relationships are caring or not has consequences for both patients and practitioners, especially nurses (Halldorsdottir, 1991; Swanson, 1999).

These relationships and their impact on the care experience are captured in the shift from externally generated problem solutions to inner-oriented, ontological, human-caring relational changes, at several levels (Tresolini and Pew-Fetzer Task Force, 1994):

- Practitioner-to-patient relationship
- Practitioner-to-practitioner relationship
- Practitioner-to-community relationship
- Practitioner-to-self relationship

6 Putting Patients First

Each of these levels is informed and affected by one's understanding and exploration of human caring as the ethical and philosophical foundation for professional practice, as well as an action component. Caring relationships at all levels affect health and healing outcomes and become the basis for understanding the critical nature of patient communications, for developing human (caring-ontological) competencies, and for cultivating relationship-centered caring at all levels of one's life and work.

RELATIONSHIP-CENTERED CARE/CARING

Planetree has always believed that the way care is delivered is as important as the care itself, and the Relationship-Centered Care (RCC) model focuses its full attention on this issue. RCC emerged from the original Pew-Fetzer Task Force, an interdisciplinary project that sought to advance all health professional education beyond the conventional biomedical, technical orientation and toward an expanded model for healing. This focus acknowledged that *relationships* are critical to the care provided by all health practitioners, regardless of discipline or subspecialty and holds a central place in education and practice (Tresolini and Pew-Fetzer Task Force, 1994, p. 11). Further, this term conveys the importance of human-to-human interaction, of human-to-human caring and connections, as the foundation of any therapeutic or healing activity. Relationship-centered care/caring likewise locates health care within a context of multiple and diverse relationships, which put into action "a paradigm of health that integrates caring, healing, and community" (Tresolini and Pew-Fetzer Task Force, 1994, p. 19).

This philosophy brings forth deeply human connections and opens up the subjective/intersubjective world and the relational connections between and among all aspects of one's life and one's interactions. This model therefore does not and cannot stand outside in some detached, abstract construction of practitioner-patient-community relationships. Rather, this model invites the full self of practitioner to engage in the full self of the patient, whereby the subjective world of both are brought closer together (Tresolini and Pew-Fetzer Task Force, 1994, p. 22) through a human-to-human intersubjective caring connection (Watson, 1999).

Concepts and Consequences of Caring/Noncaring

The caring literature in nursing science studies has identified concepts and outcomes related to constructs such as empathy, compassion, communication, hope, trust, respect, faith, love, patient-centeredness, and

relationship-centeredness (Quinn and others, 2003). The work of Swanson (1999) in particular has relevance to the significance of caring and its effects, for better or worse, depending on the presence of caring in practice models. For example, her 1999 work synthesized 130 database articles, chapters, and books on caring, published between 1980 and 1996. These studies included both empirical and theoretical-interpretive studies. Swanson summarized and categorized her findings into five levels:

- Capacity for caring (characteristics of caring persons)
- Concerns and commitments (beliefs and values that underlie nursing)
- Conditions (what affects, enhances, or inhibits the presence and practice of caring)
- Caring actions (what caring means to nurses and clients and what it looks like)
- Caring consequences (outcomes of caring—for both patients and nurses)

The overall summary of Swanson's findings related to consequences of caring for both patient and nurse has implications for all health professionals, as captured in Figures 1.1 and 1.2.

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|--|---|
| ■ Emotional-spiritual well-being (dignity, self-control, personhood) | ■ Humiliation, frightened, out of control, despair, helplessness, alienation, vulnerability, lingering bad memories |
| ■ Physical well-being (enhanced healing, saved lives, safety, energy, lower costs, greater comfort, less loss) | ■ Decreased healing |
| ■ Trust relationship, less alienation, greater family involvement | |

FIGURE 1.1. *Consequences of Caring/Noncaring: Patients.*

Source: Swanson, 1999, p. 54.

8 Putting Patients First

- Emotional-spiritual (sense of accomplishment, satisfaction, purpose, gratitude, preserved integrity, fulfillment, wholeness, self-esteem, living one's own philosophy, respect for life and death, reflective, love of nursing)
- Increased knowledge
- Hardened, oblivious, robot-like
- Depressed, frightened, worn down

FIGURE 1.2. *Consequences of Caring/Noncaring: Nurses.*

Source: Swanson, 1999, p. 54.

As illustrated in these figures, one's stance toward and practice of caring at the individual and system level can for better or for worse either facilitate healing or create distress for both parties. Thus, caring and one's relationship can be constructive or destructive, healing or nonhealing.

Halldorsdottir's research is considered a timeless study of this caring/noncaring relationship continuum (Halldorsdottir, 1991). Through her research, she identified five levels, or types, of *caring relationships*. These ranged from Type 1, which she named *biocidic* (toxic, life-destroying, leading to anger, despair, and decreased well-being), to Type 5, *biogenic* (life-giving and life-sustaining). The biogenic is of course the ideal kind of caring, which allows for an authentic human-to-human connection that is gratifying for both patient and nurse. As Halldorsdottir put it:

This Biogenic mode involves loving benevolence, responsiveness, generosity, mercy and compassion. A truly life-giving presence offers the other interconnectedness and fosters spiritual freedom. It involves being open to persons and giving life to the very heart of man as person, creating a relationship of openness and receptivity yet always keeping a creative distance of respect and compassion. The truly life-giving or biogenic presence restores well being and human dignity. It is a transforming personal presence that deeply changes one. For the recipient there is experienced an inrush of compassion, often like a current [1991, p. 44].

- Type 1, *biocidal*, or life destroying (toxic, leading to anger, despair, decreased well-being)
- Type 2, *biostatic*, or life restraining (cold or treated as a nuisance)
- Type 3, *biopassive*, or life neutral (apathetic or detached)
- Type 4, *bioactive*, or life sustaining (classic nurse-patient relationship, as kind, concerned, and benevolent)
- Type 5, *biogenic*, or life giving (transpersonal caring)

FIGURE 1.3. *Caring Relationships: Uncaring to Caring.*

Source: Halldorsdottir, 1991, pp. 37–49.

Figure 1.3 identifies the five types and the continuum of caring/noncaring.

The biogenic caring relationship is considered congruent with *transpersonal caring* and Watson's *caring moment* (Watson, 1985, 1999; Quinn and others, 2003), in that the relationship is affecting both patient and nurse in a way that paradoxically transcends the moment, while both being fully present in the moment.

As Quinn and others (2003, p. A69) remind us from another point of view, these models of caring and their effect and consequences can be supported by the “enormous literature in psychoneuroimmunology, social support, love, and systems and chaos theories. . . . For example, social support has been shown to affect health status, as has love. The . . . (caring) relationship might be viewed as a type of critical social support and a particular kind of love, offered in moments of intense disequilibrium and vulnerability” toward healing. As supported by both Swanson and Halldorsdottir's work, caring has consequences, which can either be life-giving or life-draining, healthy as well as destructive for both.

A conscious, informed, intentional approach to better our understanding of caring and relationship is necessary for true professional practices if we are to assume ethical as well as empirical-practical responsibility for sustaining caring at the individual, system, and societal levels.

It is through relationships and caring that health professionals and nurses in particular are to sustain caring and healing practices through the formal cultivation of such relational caring competencies, moving closer to biogenic–transpersonal caring. At the same time, it has to be acknowledged that “the biggest ‘psychosocial’ problem facing us

may be the need for our own personal transformation—to understand and promote change within ourselves” (Tresolini and Pew-Fetzer Task Force, 1994, p. 24).

Practitioner-to-Self Relationship

The practitioner-to-self relationship is grounded in self-awareness, self-reflection, and specific lifelong practices, which cultivate a caring consciousness, loving-kindness, and equanimity toward self. Cultivating a loving, caring relationship with self generates such feelings toward others. This is referred to as *caritas* (Watson, 2008), drawing upon the Latin association, which makes a connection between caring and love, reminding us that caring is something precious and fragile and has to be cultivated. One of Watson’s original core *carative factors* (1979, p. 9) for a caring model was “cultivation of sensitivity to one’s self and others,” which in turn helps “develop a helping-trusting human caring relationship” and instills faith, hope, and trust.

In this framework of starting with self and one’s relationship with self, we acknowledge, “To be human is to feel. . . . but all too often people allow themselves to think their thoughts, but not to feel their feelings” (Watson, 1979, p. 16). Further, we rarely build in a self-responsibility to pay attention to our feelings to the extent that we are able to cultivate skill in witnessing and reflecting on our own behavior, reactions, moods, and emotions. We rarely are taught about honoring our emotions, witnessing them, becoming familiar with them. Through this process of attending to and reflecting on our emotions, we are allowing them to pass through us, to be released or channeled, rather than holding and freezing the emotions. It is in lack of self-awareness and through fighting our emotions, holding onto them, justifying them, and so on, that our feelings torture or control us with internal psychic fights. Conversely, when we cultivate an emotional awareness and even an *emotional intelligence* of self-acceptance, self-love, and patience, we are learning how to generate an inner peace and calm for self, thereby becoming a healing presence for self and others.

It is through this beginning point of attending to our self-awareness that we cultivate our spiritual growth and our ability to witness our dynamic changing feelings. We also learn that our feelings often control us. We learn to see how often we freeze and set our emotions, creating more discomfort for our self and others. In contrast, when we honor our relationship with our self in kind, caring, loving ways, we learn that our feelings give us insight into our shared human condition. We learn in

this model that we all have emotions and feelings, but *we are not our emotions and feelings* (Watson, 1999).

The development of self-growth and sensitivity to self evolves from emotional work and emotional insights. This effort requires the nurturing of judgment, taste, values, and sensitivity in human relationships in general. The development of feelings of caring and compassion can expand and deepen through the study of the humanities: arts, aesthetics, drama, film, and literature, as well as through diverse life experiences with persons with different values, cultures, belief systems, and geographical and national settings, which can cultivate compassion and understanding that take us beyond our limited perceptions and set opinions about judging others. The recognition and development of such understanding generates knowledge and wisdom, which leads to self-growth; self-acceptance; and the practices of patience, loving-kindness, equanimity, and forgiveness toward self first, then toward others.

In this model, we are awakened to the process of learning from self and one another how to be more human—how to identify our inner self with others, finding the dilemmas of others in ourselves. “What we learn from it is self-knowledge. The self we learn about or discover is every self. It is universal—the human self. We learn to recognize ourselves in others” (Watson, 1979, p. 59).

People are often afraid to look within because they fear that if they are honest, they will see only imperfections, which can be threatening. It seems easier to push back feelings, to deny them, to refuse to deal with them or to become consumed by them. All of these are harsh approaches toward self. Those who are not sensitive to their own feelings find it difficult to be sensitive to the feelings of others. Those who repress their own feelings may be unable to allow others to express or explore their feelings. However, caring and compassionate approaches to one’s own feelings, allowing for imperfections, accepting self with both strengths and weaknesses, all become part of honoring one’s own humanity (Watson, 1979).

We learn through this process how to avoid making negative judgments and critical reviews toward self and others—realizing that the feelings of others are not unlike our own feelings. We also learn that the feelings of others do not have to threaten us, making us want to cut off someone else’s feelings. Through cultivating a loving-kindness toward self, we become more caring, loving, and kind toward others; as we become less judging of our own emotions, we become more open, more receptive, more allowing, more honoring and thus more therapeutic and more

healing for self and other. Such emotional learning is foundational to relationship-centered caring practices and is the ground from which healing and health emerge.

Practitioner-to-Patient Relationship

The practitioner-to-patient relationship is directly affected by and generated from one's relationship with self. The foundation for a caring-healing relationship with other requires deepening one's own humanity, with cultivation of specific skills, knowledge, and values. These specific aspects of relationship and communication flow directly from self and one's own ability to BE PRESENT to self and other. Thus self-awareness and being authentically present become the most basic starting point for relationship-centered caring.

Being Present: A Caring Moment

Being present requires specific knowledge and skills related to the human dimensions of *being-in-right-relation* with self. It requires cultivation of mindfulness and a consciousness of caring and healing—in the moment. Being present requires being authentically oneself, not a role model or a professional facade with distant, clinical preconceived judgments and impressions. It requires staying in the other's frame of reference with active, attentive listening, without judgment. It requires hearing the message and voice of other—hearing the tone behind the words, listening to and seeing the body language. Relationship-centered caring (RCC) from practitioner to patient requires listening with the third ear, listening to the inner voice of one's own intuition. This skill requires recognizing the patient's life story and its meaning to the person, realizing that listening to a patient's story may be the greatest healing gift we can offer.

This authentic *presencing of being* creates a *caring moment*, where the practitioner is open to receive other, connecting with the spirit of other, beyond just the body physical-ego other. RCC within a caring moment finds the practitioner centered, conscious, mindful, intentional, and available to what is presenting itself in the communication/relationship—in the moment. This process is what creates a *caring moment*, which in turn can become a healing moment. A caring-healing moment affects both practitioner and patient, in the moment, but extends beyond the moment, for better or for worse, depending on the practitioner's presence and basic starting point. This depth of understanding both *caring* and *relationship* is the basis for biogenic caring and transpersonal healing moments and possibilities.

The practitioner relationship-centered caring model acknowledges that caring and relationship cannot be based solely on an individualistic model of caring but makes explicit that caring begins with self and radiates out from self to other, to family, to community, to planet Earth, even to the cosmos, affecting the entire infinity field of humanity (Levinas, 1969; Watson, 2005). This notion of caring as *caritas* extends beyond an individual conveying a deeper level than conventional thinking. This concept of *caritas* makes the relationship between caring and love and extends to nature and the larger universe (Watson, 2005, 2007).

Caritas to Communitas

In extending caring to a model of *caritas*, or *clinical caritas* (Watson, 2004a), the underlying values are made explicit. This notion of *caritas*/deep caring is consistent with Nightingale's sense of *calling* for those in nursing and health care generally as a commitment to a professional and personal covenantal ethic of compassionate human service that is guided by an "altruistic-humanistic value system" (Watson, 1979). It is acknowledged in this extended framework that caring is a phenomenon that is to be cherished. It is fragile, delicate, and precious, requiring attention and cultivation to sustain. "When caring and love come together to serve humankind, we discover and affirm that caring-healing work is more than just a job, but a life-giving and life-receiving (biogenic) career for a lifetime of growth and learning" (Watson, 2007).

As this model becomes more explicit, we are more able to integrate the past with the present and the future. Such maturity and evolution requires (consistent with the Pew-Fetzer Task Force report): transforming self and those we serve, including our institutions and the professions themselves. As we more publicly and professionally assert a model of caring relationship, grounded in notions of *caritas* and biogenic/transpersonal dimensions of caring for self and other, we locate our self and health care within a new emerging cosmology of caring and loving as part of healing relationships. Through this shift, we call forth a sense of reverence and sacredness with respect to self, other, and all living things, thus invoking and transposing *caritas* to extend to *communitas* in thinking and actions, as a new and deep form of caring relationship (Watson, 2005). When *caritas*, love, and caring manifest at the community level, the notion of a moral community emerges. Such a community of caring consciousness for self and others exemplifies the concept of *communitas*.

Communitas

This interconnection between *caritas* and *communitas* makes explicit that we belong to a shared humanity and are connected with one another. In this way, we share our collective humanity across time and space and are bound together in this infinite universal field, which holds the totality of life itself.

The attention to cultivation of practitioner to community relationship is based further on an ethic and ethos of shared humanity, which reminds us that we learn to be more human by seeing our self in the other, and vice versa, realizing that one level of humanity reflects back on the other. This ethic and ethos is located within an emerging cosmology referred to as a *unitary consciousness* (Watson, 1999), noting that everything in the universe is connected, not separate and disconnected. Thus, we learn to be more open, more available, more present to the wonders of life itself, bonding us through the very breath of life, honoring the fact that we share the very air we breathe. *Caritas* and *communitas* define an emerging global ethic of caring-healing through relationships, belonging, and connectedness, which helps us restore the sacred in the midst of everyday existence.

Developing and sustaining deeper understanding of community—within both a concrete, local, and immediate sense and a universal *communitas* sense—forms the foundation for effective human caring. It is in recognizing, honoring, and incorporating a caring-communitarian ethic and ethos into our practice models that we help sustain individual and community. Further, it is through giving expanded attention to community relations that we bring forth our belongingness, our connectedness, and our shared human conditions. It is through this awareness and awakening that we cultivate more compassion, wisdom, and skills for caring relations, individually and collectively. It is through this awakening that we become agents and instruments for a moral community of caring. Thus, in this model we are moving toward a greater appreciation for the role of community and social support in health and healing.

ROLE OF SOCIAL SUPPORT IN HEALTH AND HEALING

Positive interactions between patients and staff members are fundamental, but do they demonstrably contribute to health and healing? Is there evidence that caring and kindness are better medicine? Few studies have been done in a hospital setting to examine the health benefits of interactions

with staff members, but there are many other examples suggesting that social connections have a positive effect on health outcomes.

In a seventeen-year follow-up on the 6,848 adults who participated in an Alameda County study, it was found that women who were socially isolated had a significantly elevated risk of dying of cancer of all sites, and men with few social connections also showed significantly poorer cancer survival rates (Reynolds and Kaplan, 1990). David Spiegel, in his book *Living Beyond Limits* (1993), cites many studies linking cancer survival to social support. Spiegel proposes several possibilities for the positive effects, including the notion that social support may affect the quality of a patient's basic activities, such as eating and sleeping, and may help patients interact more effectively with their physicians. He also suggests that social support may serve as a buffer against stress, possibly decreasing the production of stress hormones such as cortisol and prolactin. Stress is known to have a deleterious effect on the immune system. Heart disease, the leading cause of death in the United States, has also been closely correlated with a low level of social support. At Duke University, a study of nearly fourteen hundred men and women diagnosed with coronary artery disease found that 50 percent of those who were socially isolated died within five years, compared with 17 percent of those living with a spouse (Williams and others, 1992). Many other studies report findings that loneliness, isolation, and lack of social support contribute to illness and premature death (Blazer, 1982; Berkman, Leo-Summers, and Horwitz, 1992; Wiklund and others, 1988). Dean Ornish, in his book *Love and Survival* (1988), cites many studies supporting the link between social connectedness and health outcomes.

Social support also seems to alleviate the physiological effects of stress. Kamarck, Manuck, and Jennings (1990) found that when women were asked to complete a mental math problem alone, their systolic blood pressure and heart rate were significantly higher than if they were allowed to have a friend with them. In a similar study, participants were asked to give a speech, either alone, in the presence of a supportive person, or in the presence of a nonsupportive person. Those with a supportive person present during the speech experienced the least change in blood pressure, whereas those in the presence of a nonsupportive person exhibited the greatest rise in blood pressure—even more than those who gave the speech alone (Lepore, Mata Allen, and Evans, 1993).

Several studies define social connectedness as being married, having a confidant, meeting with others in ongoing support groups, or participating

in other activities that could foster and maintain long-term relationships. (The importance of these relationships will be covered in depth in Chapter Three, which discusses the role of family and friends.) One could make the case that a brief interaction with a nurse, laboratory technician, or other health care provider might not be enduring or significant enough to have any effect on the patient. But the Lepore study suggests that positive support during stressful events can minimize stress, whereas a nonsupportive person can exacerbate the stress. The stress of giving a speech might be comparable to what patients experience when undergoing a frightening medical procedure.

It is not uncommon in focus groups to hear descriptions from patients of how one caring person, even one brief interaction with a caring person—someone who listened to or supported the patient at a difficult time—changed the patient’s experience. Not infrequently, patients state that the person who listened or seemed most caring was a hospital housekeeper. This is one reason why Planetree considers everyone who works in a hospital or in any related health care field to be a caregiver. From a patient’s perspective, the title or job description of someone caring is of less importance than the fact that the caregiver is providing emotional support.

Until we have additional evidence regarding the potential health benefits of human interactions, we can build a strong argument for the importance of caring interactions and their impact on measures of patient satisfaction. Many questions asked on a typical patient satisfaction survey solicit the patient’s perceptions about the manner in which care was delivered. How helpful was the staff in various departments? How willing were nurses and physicians to answer questions? How well were family members kept informed? Rarely are questions asked about the medical care itself. Was the surgical procedure performed correctly? Did you receive the correct medications? Were falls prevented? The quality of the medical care itself is usually tracked through incident reports, performance improvement measures, and reviews of adverse patient outcomes. Patient satisfaction, though not considered “hard science,” is currently the best measure of the effects of human interactions on the patient’s overall hospital experience.

The first study of patient satisfaction at a Planetree site was conducted by the University of Washington at the initial Planetree model unit. In this randomized, controlled trial of 618 patients hospitalized between 1986 and 1990, patient outcomes on the Planetree unit were compared with those on other medical-surgical units. Planetree patients

were found to be significantly more satisfied with their hospital stay, their nursing care, the social support they received, the environment on the unit, and the education they were given (Martin and others, 1998).

More recent comparisons of patient satisfaction at Planetree-affiliated hospitals with national benchmark data are explored fully in Chapter Ten, and they indicate clearly the relationship between the quality of caring and satisfaction scores.

There is a misconception that supportive interactions require more staff or more time and are therefore more costly. Although labor costs are a substantial part of any hospital budget, the interactions themselves add nothing to the budget. Kindness is free. Listening to patients or answering their questions costs nothing. It could be argued that negative interactions—alienating patients, being unresponsive to their needs, or limiting their sense of control—can be very costly in lost patient revenues and perhaps litigation. Angry, frustrated, or frightened patients may be combative, withdrawn, and less cooperative, requiring far more time than it would have taken to interact with them initially in a positive way.

Ethnography Program

Like many health care organizations, Alegant Health has historically relied heavily on surveys and focus groups to explore the perceptions of patients about the care they received. Although the data gathered has provided useful snapshots of the patient experience, it has fallen short of Alegant's goal of thoroughly understanding the needs of its patient population. In 2006, the system began supplementing its traditional feedback mechanisms with ethnographic research, which meant fully participating in the patient experience with patients—going to their home, traveling with them to a procedure, and staying with them for the duration of their visit. This approach forced Alegant to abandon preconceived notions, to set aside prior knowledge of internal processes in place, and to closely observe what their patients actually do, how they behave, and how they interact with others. Armed with this knowledge, Alegant's leadership recognized they would be poised to better understand their patients and to respond quickly and appropriately to best meet their needs.

Alegant introduced this new approach to improve its oncology service line and was supported in the effort by an outside anthropological

consulting group. With all legal clearances in place, eight oncology patients were observed “in the field.” An at-home interview was followed by two weeks of ongoing observation during treatments, office visits, diagnostic tests, and the like. The experiences of the patients were chronicled via continuous audio and video recordings of their interactions, as well as picture journaling to further document the project team’s observations. This field-work also extended to the patients’ caregivers, including interviews with staff, medical professionals, and ancillary personnel that the patients encountered throughout their hospital/treatment center visits.

Quantified, this data collection process produced more than 1,500 data points, each reflecting either an implied or an expressed patient need. A two-day ideation process followed, for which a diverse group of cancer survivors, staff, community leaders, and members of the project team were convened to examine the data collected and brainstorm solutions. The result was that those 1,500 data points were synthesized into 350 tangible ideas for improvement. The observations were particularly useful for guiding the design of the system’s first Image Recovery Center. They confirmed that when cancer patients look better, they start to feel better, and when they start to feel better, their sense of control comes back, and with it comes a renewed sense of self-confidence. Today, Alegent’s Image Recovery Center reflects these findings, promoting healing on the outside through such services as free head shaves for patients who have begun to lose their hair, skin care products, wigs, massages, manicures and pedicures, and relaxation areas. The information gathered has also guided the revision of several internal processes to help streamline the experience for patients and their families.

CONTRIBUTED BY MYRA RICCI, ALEGENT HEALTH

PUTTING CONCEPTS INTO ACTION

Achieving high patient satisfaction is likely the goal of every hospital. Mission statements from hospitals large and small, urban and rural, for-profit and nonprofit, usually include words such as *caring*, *compassionate*, *respect*, and *dignity*—all of which reflect the quality of human interactions. But putting these concepts into practice can be a difficult task. Providing patients with what they want—being valued and respected, having a sense of control, and being provided with opportunities to

participate—cannot be achieved solely by implementing programs or policies. Care partner programs, unrestricted visiting hours, and open-chart policies are of little use if they are implemented in an environment that has not addressed the quality of fundamental human interactions.

Personalized Care

The Planetree model has focused extensively on working with hospital staff members by conducting retreats for all hospital employees, to encourage supportive interactions with each patient. This chapter's case study on Stamford Hospital's retreat process underscores the effectiveness of placing staff in the role of the patient in order to sensitize them to the vulnerability and loss of control so often experienced by patients. In addition, some hospitals have tried to identify and define specific behaviors or interactions that are perceived to be beneficial, but many Planetree sites focus on the concept of providing each patient with personalized care. *Personalized care*—that each patient is a unique individual with different preferences and needs—is a vital concept to be reinforced with caregivers. What is appropriate for one patient may be inappropriate for another. One patient may wake up at 5 AM, ready for a bath and breakfast, whereas another patient may routinely stay awake until 3 AM and wish to sleep until noon. Positive interactions require personalizing the care.

Although most of us would endorse the concept of personalization, practical implementation of the concept in the health care setting can be difficult. Standardization rather than personalization has been the rule for decades. Even if there are no written policies, many unwritten perceptions form the dominant organizational culture at many institutions. Patients are weighed at 5 AM. Bed baths are given in the morning. Blood products are usually administered at night. There is typically no medical reason for the timing of these standard hospital procedures. Patients who wish to sleep late can be weighed at the same time each evening so that the information is available when the physicians make rounds in the morning. Bed baths can be given in the evening. Blood products can be administered during the day so that the patient's sleep is not disturbed by frequent checks of vital signs. Common sense is often overridden by corporate culture. "That's not the way we do things here" and "That would inconvenience the medical staff" are frequent refrains when efforts are made to implement change. Organizational transformation helps staff members question every hospital routine, even those held most sacred, so that personalization becomes standard.

Staff Retreats

When Stamford Hospital in Stamford, Connecticut, made the decision in 2004 to implement the Planetree model of care, its motivation to join was three-fold: to reinforce its commitment to patient-centered care, to increase patient satisfaction, and to support a core strategic initiative—transforming the organizational culture.

The first charge given the new Planetree coordinator was to lead staff retreats. An organizational decision was made to embrace patient-centered care by starting at the top. By participating in the retreat process, the leadership team learned a lot about themselves and the patient care experience and reaffirmed their commitment to sharing that passion and knowledge with Stamford Hospital's twenty-four hundred employees. The question posed was how to accomplish this without losing any of the positive momentum that had been generated. An aggressive plan to get all employees to a retreat within eighteen months was put in motion. Even though many perceived this as an overly ambitious and improbable goal, others knew that time was of the essence and that such a high-impact, concerted effort would be the best way to build and sustain the momentum. Patient and employee satisfaction scores told the story of the need to embrace the Planetree philosophy: patient satisfaction was in the bottom quartile, and employee satisfaction was not much better. Consisting of sixteen managers and staff members, the team of retreat facilitators was ready for the challenge.

Early on, a beautiful venue in the next town was selected to hold retreats. A hundred-year-old convent overlooking Long Island Sound proved to be a spiritual oasis for employees. Just being in the space made everyone feel special, relaxed, and at peace.

Everyone was welcomed—skeptics and believers alike; and at times, it was not easy. However, senior management was supportive and kicked off each retreat. Experiential exercises and brainstorming sessions where staff members shared ideas, role-playing, and a three-course lunch were components of the eight-hour day.

Months passed and it got easier. Employees were calling to sign up for a retreat and to join Planetree committees, and some who had attended a retreat asked if they could facilitate. Knowing their opinion counted, that they could affect the culture change, and that senior leadership supported these changes was liberating!

In the midst of this, Stamford Hospital introduced some major image changes, launching a new logo, mission, vision, and values. And for the first time, employees took part in the planning. People talked about living these organizational values and “being Planetree.”

Three years later, the results were palpable. Both patient satisfaction and employee satisfaction rose to the top quartile. Encouraged by these results, Stamford Hospital’s Planetree journey continues widespread engagement by a hospital community with a shared commitment to improving the patient experience and creating a better work environment for themselves and their peers.

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Patient Advocacy

Another important aspect of personalized care is patient advocacy: What do we do with the information obtained regarding what the patient wants? Who will support patients in obtaining what they perceive they need? Who will be the patient’s advocate?

Nurses frequently fill the role of patient advocate but often at a significant price. “Going to bat” for a patient sometimes means challenging the health care system or breaking established rules. In many hospitals, this puts the nurse in an awkward situation. Being a “good” caregiver from the patient’s perspective may mean being a troublesome employee from management’s perspective. In an organization that supports personalization and patient advocacy, nurses and other caregivers no longer have to bend or break rules to support the needs of patients.

Appreciation and Recognition of Staff

Many books have been written about the need to develop reward-and-recognition programs to acknowledge good work by staff members. Many hospitals have implemented employee-of-the-month programs and annual awards or bonuses. Although all of these have their merit, they may fail to address the underlying culture that in many typical hospitals is focused more on punitive measures than on staff acknowledgment and recognition. In focus groups with the staff, a common refrain is that although reprimands from managers and coworkers are frequent events, appreciation is shown only once a month at official

ceremonies. Of particular concern is the growing feeling that hospital employees express about the use of patient satisfaction scores in a punitive manner. Nursing and other staff lament the use of such data to “knock us over the heads” when scores fluctuate downward even a single percentage point.

Organizational transformation, though not a quick fix, can profoundly change a hierarchical, punitive culture into one with an “attitude of gratitude.” Reward-and-recognition programs are vital as formal, organizational expressions of appreciation, but they are most effective when integrated into a culture in which the appreciation and acknowledgment of others is expressed freely and frequently and is not a mandated, quantified goal for managers. For example, even though written expressions of gratitude from managers to staff members are laudable, they quickly lose credibility and value when staff members discover that they are measured requirements that their supervisors must attain in order to obtain their annual bonus.

The terms most often used—*reward*, *recognition*, and *award*—have subtle implications that they originated in a hierarchical environment. Rewards come from the top down. Managers recognize worthy staff members. As hospitals become less hierarchical, such terms as *gratitude*, *appreciation*, and *acknowledgment* will become more common. Small gestures of appreciation, such as simply saying thank you more often, can become part of a new less-hierarchical culture.

Whereas it is vital that managers and administrators acknowledge employees who best embody the organizational values, it is equally important that coworkers acknowledge one another and that all staff members feel comfortable expressing gratitude to anyone. Departments can thank other departments via notes, gifts, or celebrations. Staff members can express their appreciation not only to coworkers but also to managers, administrators, and physicians. To be effective, this culture change needs to be role-modeled first by every administrator, manager, and supervisor so that it becomes second nature to all employees.

Celebrations of organizational successes, even of small accomplishments, provide wonderful opportunities to recognize the essential role that staff members play in helping the organization succeed. Whenever the hospital or individual departments achieve goals, reach desired benchmarks, or receive media attention, opportunities can be created to honor staff members for their accomplishments. They are not merely doing their jobs; they are doing their jobs exceptionally well.

Massage for the staff is another way that hospitals can express appreciation for the efforts of their caregivers. At several Planetree

affiliates, a massage therapist brings a massage chair to a staff lounge so that caregivers can relax and feel nurtured during a break. Some hospitals provide gift certificates to staff members for massages as thank-you gifts to recognize their contribution to the hospital.

These simple human interactions can provide an environment of gratitude in which staff members are frequently reminded that they are valued and that their work is appreciated.

Communication and Participation

Two-way communication (being informed and being heard) is another interaction that contributes to staff satisfaction. When staff members are informed, they are better able to participate in creating a work environment in which they can thrive. A structure needs to be established, however, that solicits their input and encourages their ideas and solutions.

Lack of information leads to rumors and speculation. At focus groups, some employees have complained that their only source of information about the hospital comes from the local newspaper. In the old hierarchical model, staff members were kept uninformed because of the misconception that they didn't need to know, wouldn't be able to understand the information, or might be needlessly upset, particularly if the hospital was experiencing financial difficulties. In reality, staff members are usually quick to perceive problems and are fearful and frustrated when uninformed. Withholding information or—as is more often the case—not making the effort to provide it creates anxiety, mistrust, and an “us-versus-them” environment.

Employee newsletters, e-mail, written communications, and frequent town-hall-style meetings are useful tools for keeping hospital staff informed. Expecting information to pass unimpeded through several levels and still reach the staff is wishful (and hierarchical) thinking. It is not uncommon for administrators to provide information to managers who are in turn expected to pass the information along to the staff. Some managers are effective at relaying the information but many are not. Direct communication is the most reliable. It is also helpful for managers to understand the importance of conveying information.

To be most effective, communication needs to be two-way: staff members want to be kept informed, but they also need an opportunity to be heard. Having a voice in how care is delivered and having opportunities to participate creates an environment in which staff members can be the exceptional caregivers they want to be. It is a misconception that the benefit of staff input is simply to win their support and buy-in. The opinions, ideas, suggestions, and creative solutions of caregivers

are tremendous assets in creating a healing environment for patients and an optimum working environment for the staff.

Good leadership is vital in creating an environment that supports staff participation. The hospital's leadership also plays a key role in supporting the transformation of the organization. One of the central roles of leadership is to support and articulate the highest vision of the organization. Focusing on financial success is essential, but if that is the ultimate vision of the organization, it may be difficult to enlist staff members to achieve that goal. Most caregivers did not choose their jobs or professions with the goal of helping an institution's bottom line. Nor do patients choose to come to a hospital for the purpose of enhancing its financial viability. Organizational transformation is only possible when everyone who is part of that organization has a clear vision of the ultimate goal. For the vision to become a reality, staff members must feel valued themselves so that they can communicate a sense of caring to patients.

Understanding of all these dimensions and vicissitudes of relationship and caring is the basis for creating a more integrated model of caring-healing, of *caritas* to *communitas*. The relationship that practitioners form with self, with patient, with community, and with other practitioners is critical and requires balanced attention to transform education and practice as well as practitioners themselves, be they students or skilled clinicians. (Tresolini and Pew-Fetzer Task Force, 1994, p. 37). The Planetree model and its emphasis on putting patients first serves as a moral and spiritual template for transforming the human interactions in health care, which ultimately serves as the core for sustaining caring, all relationships, and humanity itself.

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