It May Be a Dog’s Life But the Relationship with Her Owners Is Also Key to Her Health and Well Being: Communication in Veterinary Medicine

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I am writing to you, to describe the situation I had to deal with, because I took my dog to Random Animal Hospital. Never have I seen such incompetence. My dog did not receive proper care. It was obvious that this veterinarian wanted nothing more from me than my money and he charged me as much as he could. But, my dog was in worse condition after Dr. X was finished with him that afternoon. And I felt like I was part of a three ring circus, due to the numerous people I didn’t even know but had to deal with when I was at the Hospital with Toby. . . . This was probably the worst experience I’ve had in my life.

The excerpt above comes from a review of letters of complaint to the College of Veterinarians of Ontario (CVO). It illustrates one of the most pervasive problems in veterinary practice today: a lack of trust and poor communication that clients experience with veterinary professionals. A recent issue of Update, a newsletter published by the CVO, reported that 60% to 67% of complaints from 2002 to 2004 contained some concern regarding communication [1]. A list too extensive to include in this article was published itemizing the most prevalent types of communication problems found in the complaint letters. These included failure to ask for the pet’s name, return phone calls, obtain consent, provide postoperative instructions, or demonstrate empathy at the end of a pet’s life. Poor communication in human medicine has been associated with higher rates of medication errors, patient dissatisfaction,

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nonadherence, suboptimal biomedical and psychosocial outcomes, and claims for medical malpractice [2].

An emerging line of research in veterinary medicine has begun to investigate the impact of communication on small animal veterinarian–client–patient consultations [3]. Despite obvious differences between human and veterinary medicine, it is clear that there is substantial overlap in the kinds of communication mishaps found in both. Over-reliance on technology, a disease-based approach to training and practice, and pressing economic considerations may result in relationships that fail to meet client expectations.

Problems in communication have been recognized in the practice community and more recently in schools of veterinary medicine. As a result, significant gaps in communication and management skills training for veterinary students have been identified [4,5]. In response to the issues raised by these studies, a consortium of veterinary schools has attempted to define the competencies needed for practice success in veterinary medicine. With the assistance of the organizational consulting firm Personnel Decision International a list of non-technical competencies deemed necessary for practice success was generated. Communication was especially featured [6].

In 2002, Lloyd and Walsh [7] developed a recommended curriculum intended to prepare entry-level graduates for success in practice. In a recent survey by Lloyd and King [8], 23 of the 27 participating veterinary schools in the United States indicated they were making changes to respond to the KPMG study. These changes fell into the categories of admissions, orientation, curriculum, cocurricular, and other. The other category included administrative changes, the development of a combined degree program (such as the DVM-MBA), and training in research. It was also noted that curricular changes were the most widely reported response to the recommendations made by the KPMG study. Targeted additions to the curriculum included team building, business management, marketing, professionalism and interpersonal skills, law/ethics, personal finances, communication, entrepreneurship, and life skills. Although Lloyd and King [8] concluded that “widespread programmatic changes are being implemented in the veterinary schools and colleges” it is not clear exactly what these schools are doing differently and whether they are addressing all of the nontechnical competencies listed or only a select group.

Until recently, communication skills were part of the informal curriculum, learned through practical experience, and without a formal assessment or evaluation process. It seems logical that as the veterinary profession moves to embrace communication skills training in a spectrum of settings from core curricula at veterinary schools to continuing education, efforts should be made to understand the best practices and most effective methods for teaching, learning, and application of communication skills to small and large animal practice settings.

Serious initiatives are underway to provide continuing education on communication topics and skill building for practicing veterinarians. Mega-conferences, including the North American Veterinary Conference, offer a yearly full-day interactive workshop on communication skills for practice. The
American Animal Hospital Association offers a 3-day intensive program for all members of the veterinary team. The emphasis of this program is on team-based communication. Likewise, pharmaceutical and pet food companies recognize the importance of good communication skills and have provided funding for communication research and larger practice initiatives. More recently the National Board of Veterinary Medical Examiners has included assessment of clinical communication skills as part of its examination process for foreign-trained veterinarians.

In this short article, we offer a framework for communicating with clients and colleagues that links elements of communication with processes and outcomes of care. Using excerpts from letters of complaint, we also provide practical examples of how clinical communication skills can lead to more effective client relationships in practice. We also offer our ideas about how to develop an individual communication skills repertoire in practice. Our goal is to add momentum and empiric support for recognizing the importance of practice-level communication skills in achieving successful clinical outcomes.

**EVIDENCE-BASED MODEL FOR COMMUNICATING IN PRACTICE**

The Four Habits Approach

The Four Habits approach was originally developed to synthesize the literature on patient- and relationship-centered interviewing effectiveness in human medicine. This model is based on what physicians actually do in practice plus additional strategies that they find practical and useful for practice. Relationship-centered care is founded on four principles: (1) relationships should encompass the entire personhood of the participants, (2) emotions are an important part of these relationships, (3) providers and patients can and do influence one another, and (4) forming genuine relationships in health care is morally valuable [9].

The original model, published as a monograph in 1996 and updated in 2003, was designed for educational and research purposes [10,11]. In the time that it has been in use, more than 10,000 physicians have been trained using the approach. The model has been shown to be valid and reliable [12]. Further, there is support to show that physicians trained in the model score higher in patient satisfaction scores for a period of at least 6 months posttraining compared with physicians not trained in this model [13].

It was Aristotle (384 BC–322 BC) who said, “We are what we repeatedly do. Excellence then, is not an act, but a habit.” We use the term habit to denote an organized pattern of thinking and acting during the clinical encounter. Much as clinicians use pattern recognition to think about and diagnose disease, the Four Habits—invest in the beginning, elicit the patient’s perspective, demonstrate empathy, and invest in the end—provide the background for clinicians to recognize and embody effective communication strategies. The goals of the Four Habits are to establish rapport and build trust rapidly, facilitate the effective exchange of information, demonstrate caring and concern, and increase the likelihood of adherence and positive health outcomes, respectively. In addition to the
relevance of the model in human medicine, the Four Habits model has high applicability to veterinary practice.

A growing evidence base suggests that patients and physicians derive considerable satisfaction from interpersonal aspects of care [14]. It also documents that certain clinician behaviors affect the likelihood of achieving desired outcomes or avoiding negative outcomes, such as medical malpractice [15,16]. From an educational perspective there is ample evidence that clinical communication skills can be taught, learned, and practiced [17]. It is our contention that the same increase in satisfaction and successful outcomes with effective communication also holds for veterinary medicine.

Overview of the Approach

The communication tasks that make up the Four Habits are organized into categories of skills, techniques, and payoffs (Table 1). In addition, the habits and associated skills are seen as nested and interrelated. For example, asking an animal owner or agent to share all their concerns at the beginning of a visit, exploring their perspective, and showing appropriate empathy all set the stage for successfully engaging in joint decision making and education.

Habit 1: Invest in the Beginning

Three key skills come into play at the beginning of the client encounter with the practitioner. These are: creating rapport quickly, eliciting the full spectrum of concerns, and planning the visit.

Creating rapport quickly

The first few moments of the veterinary encounter are often treated as small talk and irrelevant to the clinical business at hand. Although this may be true in a narrow technical sense, the opening moments are a gateway for establishing trust and creating a lasting impression of the encounter from a communication perspective.

Once beyond the opening moments and small talk it seems that veterinarians do not use skills, such as open-ended questioning, that are known to create rapport. For example, Shaw and colleagues [3] found that only 7% of veterinarian time was spent gathering data using open-ended questions. The dominant form of question asking in this study was closed ended. This form of inquiry limits a client’s ability to respond with additional concerns as the example provided in Box 1 illustrates.

Notice in this example that there is no attempt on the veterinarian’s part to join with the client. Instead a series of closed-ended questions has been used to elicit biomedical information. The pattern of questioning limits the owner/client to a series of yes or no replies from which it is difficult to discern if there are any additional concerns. This type of interviewing style is characteristic of a veterinarian-centered approach. In human medicine, this approach is associated with poor adherence, satisfaction, and trust [18,19].

The example in Box 2 illustrates a veterinarian using several Habit 1 skills to elicit the full spectrum of client concerns about the pet. Notice how this line of questioning focuses first on the relationship by inquiring about something
shared in the last visit before entering into the business of the current encounter. Addressing the relationship first sets the tone for opening the clinical inquiry about the reason for the pet’s visit.

In addition, the veterinarian uses open-ended questions that elicit factual and affective information from the client. The veterinarian also uses a linguistic device known as a re-completer to facilitate the relationship and elicit high-quality clinical information. After the client says “She’s just sort of been listless lately,” the veterinarian simply repeats a key word, listless, with an upwardly rising intonation. This functions as an invitation to tell the story that is the context for her statement about the pet’s condition.

After the patient introduces the story with “Yes, it started about 3 days ago” the veterinarian uses another linguistic device known as a continuer. These are vocalizations, such as “mmh mh,” “go on,” “I see,” that encourage the speaker to elaborate on the content and emotional impact of what she is saying. In this case, the veterinarian’s open-ended continuer produces a statement of concern on the owner/client’s part. The veterinarian’s silence at this point produces strong affect, as the owner/client asserts: “I’m scared to death that she might have gotten rabies.” In developing an approach to the owner/client, this is potentially important information because it provides a convincing rationale for why the owner/client is seeking care for her pet.

There is little time difference between these approaches. In human medicine it takes about 1 minute longer to invest in the relationship and encourage the full expression of concerns than to remain exclusively problem- or disease-focused [20]. The extra minute seems to be time well spent. As a habit of practice one might think about inquiring about and noting something personal in each owner/client’s chart after each visit and using it as an opening inquiry in the next visit.

The payoff for Habit 1 is that clients feel welcomed, safe, and listened to, within a framework and organization for the visit that is clear and explicit. The value of this habit in human medicine has been demonstrated in research conducted by the Headache Study Group at the University of Western Ontario [21]. They found that the strongest predictor of resolution of chronic headache symptoms at 1 year follow-up was the perception on the patient’s part that the clinician had listened completely to all of their concerns in the first visit. Investing in the beginning sets the stage and tone and provides the plan for the rest of the visit.

Habit 2: Elicit the Owner’s/Client’s Perspective

In human medicine, the current climate of consumer demand for high-quality care and information, ethical and legal standards requiring that patients be fully informed, and increasing concern about poor communication as a source of medical errors all point to the importance of eliciting the patient’s perspective. As recently as July 2006, an Institute of Medicine report on medication errors noted the critical importance of a paradigm shift from doctor-centered to patient- and relationship-centered communication stating that “one of the most effective ways to reduce medication errors is to move toward a model of health care where there is more of a partnership between the patients and the health care providers” [22].
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<tr>
<th>Habit</th>
<th>Skills</th>
<th>Techniques and examples</th>
<th>Payoff</th>
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<tbody>
<tr>
<td>Invest in the beginning</td>
<td>Create rapport quickly Elicit client’s concerns Plan the visit with the client</td>
<td>Introduce self Acknowledge wait Convey knowledge of patient’s history by commenting on prior visit or problem Attend to patient/client comfort Make a social comment or ask a nonmedical question to put client at ease Adapt own language, pace, and posture in response to client Start with open-ended questions: “What would you like help with today?” “I understand that you’re here for... Could you tell me more about that?” “What else?” Speak directly with client when using an interpreter Repeat concerns back to check understanding Let client know what to expect: “How about if we start with talking more about... then I’ll do an exam, and then we’ll go over possible tests/ways to treat this? Sound OK?” Prioritize when necessary: “Let’s make sure we talk about X and Y. It sounds like you also want to make sure we cover Z. If we can’t get to the other concerns, let’s...”</td>
<td>Establishes a welcoming atmosphere Allows faster access to real reason for visit Increases diagnostic accuracy Requires less work Minimizes “Oh, by the way...” at the end of visit Facilitates negotiating an agenda Decreases potential for conflict</td>
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### Elicit the patient’s perspective

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<tr>
<th>Action</th>
<th>Example</th>
<th>Effect</th>
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<tbody>
<tr>
<td>Ask for client’s ideas</td>
<td>“What do you think is causing your symptoms?”</td>
<td>Respects diversity</td>
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<tr>
<td>Elicit specific requests</td>
<td>“What worries you most about this problem?”</td>
<td>Allows client to provide important diagnostic clues</td>
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<tr>
<td>Explore the impact on the patient/client’s life</td>
<td>Ask about ideas from significant others</td>
<td>Uncovers hidden concerns</td>
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<tr>
<td>Determine client’s goal in seeking care:</td>
<td>Determine client’s goal in seeking care:</td>
<td>Reveals use of alternative treatments or requests for tests</td>
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<td>“When you’ve been thinking about this visit, how were you hoping I could help?”</td>
<td></td>
<td>Improves diagnosis of depression and anxiety</td>
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<td>Check context: “How has the illness affected daily activities?”</td>
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### Demonstrate empathy

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<tr>
<th>Action</th>
<th>Example</th>
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<tr>
<td>Be open to client’s emotions</td>
<td>Assess changes in body language and voice tone</td>
<td>Adds depth and meaning to the visit</td>
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<td>Make at least one empathic statement</td>
<td>Look for opportunities to use brief empathetic comments or gestures</td>
<td>Builds trust, leading to better diagnostic information, adherence, and outcomes</td>
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<tr>
<td>Convey empathy nonverbally</td>
<td>Name a likely emotion: “That sounds really upsetting.”</td>
<td>Makes limit-setting or saying “no” easier</td>
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<td>Be aware of your own reactions</td>
<td>Compliment patient on efforts to address problem</td>
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<td></td>
<td>Use a pause, touch, or facial expression</td>
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<td></td>
<td>Use own emotional response as a clue to what client might be feeling</td>
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<td></td>
<td>Take a brief break if necessary</td>
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<th>Habit</th>
<th>Skills</th>
<th>Techniques and examples</th>
<th>Payoff</th>
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<tbody>
<tr>
<td>Invest in the end</td>
<td>Deliver diagnostic information</td>
<td>Frame diagnosis in terms of client’s original concerns</td>
<td>Increases potential for collaboration</td>
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<td></td>
<td>Provide education</td>
<td>Test client’s comprehension</td>
<td>Influences health outcomes</td>
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<td></td>
<td>Involve client in making decisions</td>
<td>Explain rationale for tests and treatments</td>
<td>Improves adherence</td>
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<td></td>
<td>Complete the visit</td>
<td>Review possible side effects and expected course of recovery</td>
<td>Reduces return calls and visits</td>
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<td>Recommend lifestyle changes</td>
<td>Encourages self care</td>
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<td>Provide written materials and refer to other sources</td>
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<td></td>
<td>Discuss treatment goals</td>
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<td>Explore options, listening for the client’s preferences</td>
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<td></td>
<td></td>
<td>Set limits respectfully: “I can understand how getting that test makes sense to you. From my point of view, since the results won’t help us diagnose or treat the symptoms, I suggest we consider this instead.”</td>
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<td></td>
<td></td>
<td>Assess client’s ability and motivation to carry out plan</td>
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<td>Ask for additional questions: “What questions do you have?”</td>
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<td></td>
<td></td>
<td>Assess satisfaction: “Did you get what you needed?”</td>
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<tr>
<td></td>
<td></td>
<td>Reassure client of ongoing care</td>
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*Adapted from Frankel RM, Stein T, Krupat E. The four habits approach to effective clinical communication. Oakland, CA: Kaiser Permanente; 2003. p. 17; with permission.*
Although acknowledged as important to the care process, many physicians, and veterinarians do not avail themselves of the opportunity to build partnerships during the interview. Such missed opportunities relate to increased non-adherence and medication errors. A study by Braddock and coworkers [23] found that only one in five primary care physicians and surgeons inquired about the perspectives of their patients. According to the authors the rationale for exploring patient perspectives is that “Physicians may assume that patients will speak up if they disagree with a decision, but patients often need to be

**Box 1: Opening the visit: closed questioning**

**Vet:** Hello Ms. Jones. What problems is Fluffy having?  
**Owner:** She’s just sort of been listless lately.  
**Vet:** When did it begin?  
**Owner:** It started about 3 days ago.  
**Vet:** What was going on then?  
**Owner:** She was out in the back yard chasing squirrels and when she came back in she just went to her bed and laid down. She’s been sort of listless ever since.  
**Vet:** Has she been eating okay?  
**Owner:** I think so.  
**Vet:** Any coughing or vomiting?  
**Owner:** No.  
**Vet:** Going to the bathroom regularly?  
**Owner:** Yes  
**Vet:** Noticed any loose stool?  
**Owner:** No.

**Box 2: Using open-ended questions to build relationships**

**Vet:** Hi Ms. Jones. It’s good to see you again. How have you been since I saw you last? I seem to remember that you were just leaving to go visit your daughter in Holland. How was your visit with her?  
**Owner:** Oh it was marvelous. Thanks for asking!  
**Vet:** Sure, and how is Fluffy doing since she was here last?  
**Owner:** She’s just sort of been listless lately.  
**Vet:** Listless?  
**Owner:** Yes it started about 3 days ago.  
**Vet:** Mmh mmh.  
**Owner:** She was out in the back yard chasing squirrels and when she came back in she just went to her bed and laid down. She’s been sort of listless ever since.  
**Vet:** Mmh mmh.  
**Owner:** You know it’s really concerning to me.  
**Vet:** (Silence)  
**Owner:** I’m just scared to death that she might have gotten rabies and might have to be put down or something like that.  
**Vet:** I can see that you’re concerned and I’ll come back to that in a moment. Before I do is there anything else you’re concerned about?  
**Owner:** No.
asked for their opinion. It should be clear to the patient [and the pet owner] that it is appropriate to disagree or ask for more time” [23]. For example, asking “Does that sound reasonable?” or “What do you think?” invites patients or clients to share their views.

Habit 2 serves several important functions: showing respect for the client’s experience and individuality, developing partnerships, and comparing similarities and differences in understanding. Early work by Pantell and colleagues [24] in pediatrics showed that children who have asthma have their own needs, and addressing these can improve their satisfaction and adherence to treatment. A similar finding was recently reported by Staiger and colleagues [25], who studied low back pain in adults.

In everyday life, owner/clients frequently engage in a process similar to differential diagnosis. That is, they exclude certain causes and explanations for their observations and include others. Knowing specifically what meaning they are giving to their animals’ symptoms allows the practitioner to frame the rest of the dialog accordingly. For example, the owner in the second example (Box 2), who was “scared to death,” may seem unusually worried about symptoms that seem vague or minimal to the practitioner. Finding out the client’s attribution or source of concern by eliciting the client’s perspective often clarifies the situation and offers an opportunity to strengthen the relationship. The following excerpts from letters of complaint serve to highlight the impact of missed opportunities to determine the client’s perspective.

Letter 1

I am writing this letter to lodge a formal complaint against Dr. X. Our dog was assessed by Dr. X for dental health. He advised us to get Peppy’s teeth cleaned and possibly there would be some extractions of teeth due to bad gums. Dr. X removed 12 teeth during the cleaning! Later on he removed another 7 teeth. He did not have permission to take our dog’s teeth out. Now we have to water down his food so he can eat and he has to eat on one side of his mouth. Did our dog really need 19 teeth taken out? Dr. X did renovations to his clinic about a year ago. Could there be any connection?

—Yours sincerely, The client

Letter 2

“On January 3rd, a week after Mitsy’s next heat had finished we noticed she was drinking large amounts of water again. We called ABC Animal Hospital on January 5 and I explained my concerns to Sue, the receptionist (as well as Mitsy’s recent history at the Hospital). An appointment was made to have her looked at. The blood tests from last May were sent to the hospital as well. During the week Mitsy was eating on and off but still energetic. Both my wife and I felt blood work and X-rays were needed based on what we had learned at the previous hospital. After the examination we all agreed that Mitsy should be spayed and we booked an appointment. We were surprised that no baseline diagnostics were taken given our
In human medicine Tuckett and coworkers [26] found that patients who were able to fully explain their illnesses to their physician recalled more information and were more committed to treatment. In addition to better adherence to treatment recommendations, another payoff for Habit 2 is learning about how owner/clients view the health, illness, and disease of their pets. This information is valuable in considering how best to communicate prognostic and treatment information to owner/clients and family members. In the case above, had the veterinarian attempted to build a partnership with the owner by explaining that there was a relatively low likelihood of a serious underlying problem requiring immediate testing, the decision not to test would have been shared rather than perceived as unilateral. Although the outcome would not have changed, the owner’s perception of neglect on the part of the veterinarian might have been different.

Habit 3: Demonstrate Empathy
Caring and compassion have characterized the relationship of human and animal healers to their clients for centuries. In the modern era, great technological advances and economic pressures have led to a relative de-emphasis on the therapeutic benefits of caring and compassion in training and practice. Research in human and veterinary medicine has found low levels of empathy expressed during visits. For instance, Shaw and colleagues [3] found empathy expressed in only 7% of the 300 companion animal appointments they studied. Suchman and colleagues [27] found an even lower level of empathy in their qualitative study of empathy in human medicine. Researchers have linked the presence or absence of caring to a range of outcomes, including satisfaction, adherence to medical recommendations, and propensity to sue [28].

If caring and compassion form the core conceptual basis of the healing relationship, empathy is the core skill for enacting it (see Table 1). Although understood
to be therapeutic, empathy does not occur often in clinical encounters [3,27]. One barrier to its use is the perception of limited time availability to do anything but the most instrumental clinical tasks in the visit. Many clinicians assume that it is not possible to demonstrate empathy under such time-limited circumstances. Contrary to this belief, researchers studying an elite group of outstanding clinicians observed that they invariably found a way to respond to patient emotion using windows of opportunity, selectively attending to moments in the encounter that seemed to get to the heart of their patients’ concerns [29]. Other research supports the notion that a patient’s appreciation of an empathic response is sustaining to the clinician and adds meaning and depth to the relationship [30].

Accurately identifying emotions depends on observing nonverbal behavior, such as facial expression and body posture, and listening closely to the patient or client’s tone of voice as he or she describes the experience. In human medicine, physicians who are sensitive to nonverbal expression of emotion have more satisfied patients [31]. Likewise, physicians who use eye contact appropriately are more likely to detect and treat emotional distress [32]. There is also evidence, based on content-filtered speech, that voice tone is a reliable predictor of follow up to treatment recommendations [33].

In a study of referrals for treatment of alcohol abuse, a warm accepting tone of voice on the provider’s part was highly associated with follow-up from the referral [33]. In a recent study using specialized analysis of content-filtered speech, Ambady and colleagues [15] were successfully able to distinguish between surgeons who had never been sued and those who had been sued for malpractice at least twice.

Often patients or clients only hint at an emotion. Statements such as “Fluffy seems listless,” or “What do you think about surgery for Fluffy’s cancer?” do not express an emotion directly. Suchman and coworkers [27] defined these occurrences as potential empathic opportunities (PEOs) and suggested that they are often used by patients to test whether it is safe to talk about the underlying emotion. Clinicians who attend to emotional clues and cues improve the quality of communication and relationships with patients. Likewise, Suchman and coworkers [27] noted that when emotional clues are ignored, patients will repeat or escalate their concerns or surface them only at the end of the visit.

In the following excerpt from a letter of complaint to the CVO, a client’s experience of lack of empathy is compounded by the more routine aspects of handling animals following death and the business side of practice:

On Friday morning I received a phone call from the veterinary clinic telling me that Sasha was not well and I should come to the clinic as soon as possible. She told me she might not make it. I had promised Sasha if she was ever to leave this earth I would be with her to show my immense love for her. I had just come from the shower to get the phone. I promptly threw on my clothes and drove there. She had died before I arrived and was brought to me in a box. Only minutes later both the Dr. and the technician were both very interested in selling me a plot of land to bury her and to sell me a gravestone to commemorate her. Before I left to bury my beloved...
Sasha, and I was crying profusely, the technician had the utter audacity, gall and disrespect to ask me what I would like to do with my invoice!

Helping owners/clients move from hinting at an emotion to its full expression is part of the work of empathy. Cohen-Cole [34] identified five types of verbal statements that convey empathy and suggested a generic format for each. They are:

- Reflection—“It sounds like you’re concerned that Fluffy . . .”
- Legitimization—“Anyone would feel scared . . .”
- Support—“I will be there for you no matter what happens . . .”
- Partnership—“I think we can figure this out together . . .”
- Respect—“I have confidence that you’ll do the right thing . . .”

In addition, the use of nonverbal actions, such as silence, touch, gaze, facial expression, and body posture, are all associated with conveying empathy. The pay-off for demonstrating empathy is getting to the heart of the problem and relieving emotional distress [35]. Had the technician described in the letter above responded to the client’s strong emotion by demonstrating empathy the technician would in all likelihood have found the client more than willing to settle her account after a brief opportunity to adjust to her beloved pet’s death.

Empathy adds depth and meaning to the relationship and also builds trust. When the time comes to make difficult or complex decisions, having explored the emotional terrain surrounding the issue facilitates partnerships and informed decision making. Poignant to veterinary practice is the issue of costs. Hardee and colleagues [35] describe skills necessary for talking about cost with patients including the use of “we” statements and “I wish . . .” as a platform for shared decision making and a search for alternative approaches or plans [36]. Timing the discussion of services and costs so that they occur after empathy has been demonstrated in the face of strong client emotion ensures that subsequent discussions will take place within a trustworthy affective partnership.

Habit 4: Invest in the End

Although the first three Habits are based on gathering information, Habit 4, investing in the end, is primarily focused on information sharing. This is reflected in the tasks at the end of the encounter, namely, delivering diagnostic information, encouraging participation in decision making, and checking for understanding of recommended treatments. Communicating bad news and its effects on family members can be a real challenge. Although it may be required in practice, many physicians receive no formal training in this area as the following narrative from a senior physician recounting his training experience in delivering bad news attests:

I was a third year student on an ER rotation when a family (grandmother, 10-year-old girl, uncle of girl) came in badly burned in a house fire. The girl was in arrest and despite all efforts died. The grandmother was alive but critically burned. The smell of charred flesh was overpowering. I was sent to ask the mother for an autopsy. Instead of beginning by informing
her of the death I began with: "Sorry to bother you at this time but ..." and then asked her my question. She screamed and collapsed, hysterical at my feet. I was aghast, guilty, stunned, felt inadequate to make any appropriate response. I still feel awful about it to this day.

The costs of poor training in this area are most obvious on the patient side, although the literature suggests that physicians who make mistakes of this sort suffer also [37]. Poor outcomes and emotional wounds are a prescription for patient dissatisfaction and malpractice suits.

The following excerpt from a letter of complaint highlights the client’s experience of not having adequate information to make an informed decision about how to proceed with the care and treatment of her pet:

In September our dog was taken to see Dr. Y because of a lump in the tummy area. She had a mast cell tumor. Dr. Y advised that the cytology report was very good and that she could undergo the removal of this tumor with no complications. Rumour came through the surgery with no complications and the Dr. said she was confident that she had removed it all. We must state that at the time of this operation under no circumstances did the Dr. discuss with us any follow-up chemotherapy or preventative measures for prevention of further tumors from developing. We had NO idea there were any such measures available. A year later another lump was discovered in the same area and we took her back to the same Dr. No labs tests were performed and we were informed that Rumour was in good shape and could withstand another surgery. . . . Upon our arrival to pick Rumour up after this second surgery she was brought to us by a technician. She told us that we should immediately upon our arrival home give our dog a bath in the bathtub and then treat her stitches with hydrogen peroxide and water so she would not get infected. We were not informed when to bring her back to have her stitches removed and she was not given antibiotics or pain medication. We did as we were told and my husband bathed the dog . . .

The importance of checking for client comprehension and coming to a mutually agreed-upon plan cannot be overemphasized. In addition to shared decision making and increased adherence to follow-up, using this approach provides an ideal opportunity to educate clients about their pet’s condition and to correct any misunderstandings or misapprehensions. Grueninger and coworkers [38] suggest several helpful questions for use in optimizing comprehension and agreement. These include:

- After having discussed the various options with you is there anything that I’ve missed or anything that we need to clarify?
- Are you comfortable with the plan we’ve outlined?
- Is there anything that would make it difficult or impossible for you to follow the plan?

The payoffs from using Habit 4 are increased collaboration in decision making and a corresponding reduction in risk for error and nonadherence. Further, focusing on comprehension of diagnostic news, instructions, and recommendations, and barriers to adherence improves alignment between the health care
provider and desired outcomes of care. Finally, knowing how to sensitively deliver bad news can relieve unnecessary suffering on the client’s part and make the practice of veterinary medicine more deeply satisfying.

SUMMARY
We have reviewed more than four decades of research and evidence in human medicine that has consistently demonstrated that communication and relationship building impact the quality and outcomes of care. There is emerging evidence in veterinary medicine that many of the same challenges exist in providing clinical care for pets, who cannot speak for themselves, and their owners, who can and do. It seems that improved communication with pet owners is associated with fewer complaints, higher levels of satisfaction, and reductions in medication and other types of errors.

Growing recognition of the benefits of communication skills training has led veterinary medical educators to develop explicit curricula based on evidence of best practices. In doing so they have acknowledged that these skills belong in the formal curriculum and need to be taught just as doing accurate diagnosis and treatment are. As a result, we can expect that the next generations of veterinarians will possess outstanding skills in communicating with their clients.

What can veterinarians do to improve their communication skills in practice? Several options currently exist:

- Attend a national meeting in which workshops on communication skills are offered.
- Attend an intensive training course on communication skills offered by regional or national organizations. (In human medicine the American Academy on Communication in Healthcare and the European Association for Communication in Healthcare offer 1-, 2.5-, and 5-day intensive courses on improving communication skills. Veterinarians have been active in both organizations.)
- Contact the Institute for Healthcare Communication and learn about continuing education opportunities on communication.
- Assess your own communication skills using the Four Habits or an equivalent approach. This might include having a colleague observe you for a clinic session and provide feedback on your communication skills. Self-assessment is another possibility.
- Use letters of complaint and also those that complement the practice to work on ways to improve communication and relationships with clients and within the health care team.
- Partner with one or more colleagues to discuss challenging cases and innovative approaches to communicating more effectively.

Improved communication skills are of demonstrated benefit to clients, but the evidence is that practitioners benefit also. An emphasis on the bottom line may leave veterinarians feeling stressed and demoralized. Investing in habits of practice that result in improved relationships has the added benefit of reminding us of why we went into our chosen fields in the first place and restoring the sense of joy in serving others and alleviating suffering.
References