PATIENT ANXIETY/ EMOTIONAL INTELLIGENCE: UNLEASHING THE POWER TO CARE WITHIN A CULTURE OF EMPATHY

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March 2, 2012

I fully understood the phenomena of an "amygdala hijack" on a conceptual level. As a leadership coach, I have been learning and teaching about *emotional intelligence* and *change management* for the past twenty years. But we've learned more about how the human brain works in the past five years, than we knew in the previous fifty.

People undergoing an "amygdala hijack" (located in a small almond-shaped part of our brain that is the store-house of emotional memory) are experiencing deep primal fears – and that is what I was experiencing as I was gurnied wide-eyed and terrified under University Avenue from Mount Sinai Hospital to UHN's Munk Cardiac Centre two years ago this Christmas. "I don't know what's happening", I repeated in bewilderment to myself. I had never been a patient at a hospital before. This is all very new and frightening to me.

I was observing in slow motion how my brain was screaming questions to itself – for which it had no answers. "Some healthcare expert", I said to myself! "I actually don't know anything about cardiac healthcare". Yes, I had worked with world-famous heart surgeon Dr. Wilbert Keon of the *Ottawa Heart Institute* in the mid-90's, but we were working on how to design integrated healthcare services, not heart health.

I could clearly recall how I changed the topic each time he started talking about the government's rate for "heart stents", and his insightful analysis of the unintended consequences of their lack of systems thinking. "I don't know anything about heart surgery … this should not be happening to me," I told myself as we arrived at the operating theatre at the Munk Centre. "Why didn't I learn something, when I had the chance"?

Through an imaginary "3rd Eye" that I have mounted above my head (so that I can watch myself interact with others), I coldly and dispassionately observed my psychological meltdown as my brain raced through my deepest fears: not being able to say goodbye to my family; all the things I needed… to tell them …

My Third Eye's camera focused at last on the eyes of a surgical nurse who seemed to actually hear all the screaming silently going on in my head. I was convinced I was going to die. Very soon.

She smiled. Locked her eyes on mine, and began to wrestle with my primal fears and the riveting anxieties that gripped me to the point of very tentative, careful shallow breathing. As if she had heard all my silent panicky questions to myself, she began to introduce me to my environment, and to the doctors and nurses around me in one of five operating theaters in Munk Centre.

Did you know that the Munk Centre does about 65 angioplasties per day? It's like a factory. A really well-run factory -- specialized in doing just a few procedures -- at which they are very, very good.

When I found out that I was going to be wide awake for the expected two and a half hours of this procedure, I was terrified. I dove head-first into my nurse's deep blue eyes. I could "feel" copious quantities of anxiety departing my body as I lay there, taking in all the information she was providing me, in a voice tone that was very, very comforting.

Did you know that you would be safer in the *Munk Centre for Cardiac Surgery* than driving on the 401 on the way home? Sure, you think that data worked on me because I'm a policy wonk/ nerd … but I know it was her voice tone, her smile, and her eyes that calmed me down. She was a real pro.

"Wow", I said to myself as I watched the unfolding scene from the distance of my Third Eye, "what she is doing is actually teachable". This is what patients really need: they need health service providers who can address their anxieties in empathic, caring and compassionate ways.

Listening intently to the "patient experience" at numerous storytelling conferences over the past three years, has led me to believe that the most significant issue -- at the root of most poor patient experiences -- is "poor provider/ patient communications".

Organizations that today are leading the way providing "patient-centred care" (an estimated 15% to 20% of healthcare organizations) tend to be those who have made it a priority to create a *Culture of Empathy* – where staff across the whole organization have the "people skills" of my Munk Centre cardiac surgical nurse.

What would it be like if an organization had a "*Culture of Empathy*"? When we are empathetic, we have the capacity to perceive the subjective experience of another person. We demonstrate "empathy" when we imagine another person's feelings, emotions and sensitivities; think about how we might feel in their situation; and then behave in an appropriate way.

When we teach *emotional intelligence*, we explain how our emotions are intertwined with our words and actions – and how a shift in posture, or a moment of silence, the dart of an eye, may indicate a person's feelings – even if they do not verbalize them. Seventy percent of all communications are "non-verbal". Since people's feelings are not always

put into words, we need to be able to read these *non-verbal cues* -- such as facial expressions/ body language.

However, to be empathetic, it is necessary to be *self-aware*.
When we are *self-aware,* we are in touch with our own emotions -- and therefore are more able to read others' feelings.

Building a "*Culture of Empathy*" should be a high priority for healthcare organizations undertaking an organizational over the next two or three years. In my *Leadership Essay* about Hawkesbury Hospital CEO **Michel Lalonde** (available to members @ **tedball.com**), I wrote about his deep conviction that we needed to "care for the caregiver", if we are to liberate their capacity to care for, and, indeed, "love" our patients. That's the model we need to hold as the existing system is fundamentally transformed over the next three or four years.

What happens when you liberate front-line workers? I loved the poster story presentation at a *Patient-Centred Care Symposium* in January provided by Donna Williams, the nurse manager at UHN's Preoperative Care Unit who told how they developed an Improvement Committee to improve the experience of patients throughout their peri-operative episode of care – with particular attention given to improving the processes surrounding surgical cancellations where patients who had waited for months for their surgery where having their surgery canceled the very day of their scheduled surgery – with no new surgery date set -- as they go home to start their waiting again.

Nurses described how patients were devastated, disheartened, unsure, resigned and deeply worried. On behalf of their patients, nurses were frustrated with the current process and acknowledged the need to improve the communication between the nurse, the patient and the surgeon.

Everyone involved in the Preoperative Care Unit – including clerical and support staff, staff nurses and management – were all enthusiastic contributors to this "humanizing process" focused on patient-centred care.

With the release of the ***Drummond Report***, I think the priority job for leaders in our healthcare system needs to be: drive out fear! As is normally the case, nobody has any expectations that they have to change. So when change becomes explicit and meaningful on a personal level, fear will rise.

But the truth is, innovation simply cannot take place in a climate of fear.

The Premier had a high impact on the education system in his first term when he shifted the negative dynamics of the Harris era. If he truly wants innovation in healthcare, he and Health Minister Matthews now need to stop the inappropriate bureaucratic processes and regulations that have stifled innovation in the health sector for the past four years.

I have seen how the system trembles before the RFP police and how terrible and wasteful "following the rules" can be. It is absolutely possible to create environments where innovation and risk management co-exist together in a supportive and accountable environment.

The best way to "drive-out-fear" is to build trust throughout the health sector – through the practice of what authors like Daniel Goldman and Cooper & Sawaf have called, *Emotional Intelligence*. EI is a critical success factor in healthcare because of the existing deep levels of fear and anxiety (with the typical dynamics of "blame" and "blame avoidance"), and because of the inherent capacity within the system for caring, compassion and love.

Many front-line care providers have developed understandably cynical attitudes over the many "*Structural Fixes-That-Fail*". Their hopes and expectations have been mismanaged over the past 20 years as we go from District Health Councils, to Ministry Offices, to LHINs and to who knows what brilliant solution could possibly emerge from a committee of politicians – where the majority are committed to getting rid of LHINs – will be given the mandate to decide on the future of LHINs.

Front-line healthcare workers know that all these structures with their dysfunctional dynamics have contributed to the fact that our healthcare services are getting worse and worse. The costs of mistrust and cynicism are now very high. These emotions corrode organizations, and destroy their capacity for high-performance.

But remember: these organizations are profoundly human. Fear and a lack of trust within an organization has a direct and profound impact on the qualitative experience of clients/patients.

Trust is an integrative mechanism – the cohesion that makes it possible for organizations to accomplish extraordinary things. However, Ontario's healthcare systems cannot be transformed – until and unless trust is built across the system. David Carnvale, in ***Trustworthy Government*** says "trust and high performance are impossible if the organization deals with employees just in terms of their work roles, puts up defenses that impair free expression, uses manipulative methods to motivate workers to do what it wants, and attempts to control everything and everyone."

Carnvale concludes, "staff who are suspicious and cynical become absorbed in self-protective practices. They are less likely to take risks, to speak out when it is called for, to question ideas that need examination, or take a change that a fresh approach might be the answer to a problem." He says, "They fear speaking truth to power. Who after all, is going to expose themselves to risk, or commitment to an organization that weakens their sense of efficacy, or threatens their very existence? Who identifies with a system that keeps them small?"

Those who "think big" about what it might mean to have a truly *patient-centred system* have suggested the following ten ***Guiding Principles for Patient-Centred Care***. These are:

- Care is based on continuous healing relationship.
- Care is customized and reflects patient needs, values and choices.
- Families and friends of the patients are considered an essential part of the care ream.
- Knowledge and information are freely shared between and among patients, care partners, physicians and other caregivers.
- Patient safety is a visible priority.
- The patient is the source of control for his or her care.
- All team members are considered caregivers.
- Care is provided in a healing environment of comfort, peace and support.
- Transparency is the rule in the care of the patient.
- All caregivers cooperate with one another through a common focus on the best interests and personal goals of the patient. (Borrowed from Margaret Gerteis et al.)

Is your organization guided by these sorts of patient-focused principles?

Next week my blog will be entitled, "***Leveraged Actions & Catalytic Triggers The Art & Science Of Experience Design Methodologies***."