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FELLOWS-IN-TRAINING & EARLY CAREER PAGE

Earning Trust Through Empathy as a Young Interventionalist

"Is This Your First Time Doing This?"

Jaya R. Mallidi, MD, MHS

One year ago, on a September night, I was called to the emergency room to take care of a 65-year-old woman who presented with inferolateral ST-segment elevation myocardial infarction. As a new interventional attending physician, I was nervous, but fairly confident of my skills. As I was driving in, I did a quick mental checklist of access, guide, antithrombotic regimen, and any other potential issues that might arise. I called the catheterization laboratory staff to make sure everyone was ready. I thought I was prepared for this, until the patient's husband said, "Doctor, you look so young! Is my wife the first patient you are going to do the procedure on?"

I had been asked similar questions before during my interventional training. When obtaining consent from patients, they often asked me if I did the procedure all by myself. I always replied honestly saying that I was a fellow-in-training, I had completed several procedures, but I would be doing the procedure together with the attending physician. Although there were those rare patients who did not want a trainee even in the room, most patients seemed comfortable with this explanation. As a petite Indian woman, I had to answer these questions many more times than my cofellows. However, all my experience in answering such questions as a fellow failed me on that September night. Standing in front of a husband, whose wife was having an acute heart attack, as the attending taking care of the patient and the family, I struggled to find the right words. I struggled with a response, because there was a genuine concern and worry in his voice. I said, "No, she is not my first patient. I have done these procedures before." Then, placing my hand on his shoulder, I added, "We have an excellent team here. I will take good care of your wife, just like family." He smiled. Silently, I thanked God that my first ST-segment elevation myocardial infarction patient had been an intubated cardiac arrest patient whose family could not be immediately contacted. This patient was my second. Taking the time and effort to build trusting and collaborative relationships with patients by appropriate expressions of empathy and compassion is a powerful tool to improve patient satisfaction and overcome the inherent skepticism faced by a young interventional attending physician. The procedure was uncomplicated, and the patient and her husband expressed gratitude for the care provided.

Trust is the central component that defines a patient-physician relationship (1). Studies have shown that patient trust is strongly correlated to patient satisfaction (2,3). Patient trust is a complex, multidimensional construct that is difficult to define. It may be considered as a "reassuring feeling of confidence, or reliance in the intent, ability, knowledge and expertise of the physician" (4). In an acute medical setting, when dealing with life-threatening situations, the vulnerability of the situation can give rise to either trust or distrust (5). Trust can be influenced by patient beliefs, biases, and societal norms, and trust in collective institutions rather than an individual physician plays a more dominant role in acute situations. This is different from interpersonal trust that patients develop with a specific physician over a long period of time after repeated encounters. As an interventional cardiologist doing high-risk procedures, it is extremely important to gain the trust and confidence of the patient and the family before doing the procedure whenever possible. In an acute setting, time constraints can make this difficult. However, even in a short clinical encounter,

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"interpersonal trust" can be established, and social biases can be overcome by effective and supportive verbal and nonverbal communication, acknowledgment of patients' concerns, patience, as well as genuine compassion and empathy.

In a nonacute setting, physicians see approximately 20 patients daily (6). The focus on building a therapeutic relationship with our patients based on collaboration and trust can be easily lost when seeing several patients, as this takes effort and time. In the grueling year of interventional fellowship, the focus is predominantly on the technical aspects of patient care. The clinical encounters of fellows with patients are often short and limited to immediate pre- and post-procedural care. As an attending, this changes drastically. Most patients on whom we intervene will become our lifelong patients. Regardless, as interventional cardiologists, it is our moral obligation to spend adequate time with the patient and family to explain and address all of their concerns and develop a trusting relationship.

A few months ago, I took care of an 87-year-old priest, who is well known for his services in the community, in the setting of an acute anterior myocardial infarction. The culprit lesion—mid-left anterior descending artery—was successfully stented. He had a significant, calcified residual lesion distal to the stent that was not treated during the primary intervention. In the outpatient setting, I explained to him and his family, in great detail, the pros and cons of intervening on the calcified lesion and the need for rotational atherectomy. Despite the previous successful intervention, the patient said, "This sounds like a complicated procedure and you look young. Have you ever done this before?" I replied saying that I did only 1 other rotational atherectomy case as an attending, but I am well-trained and performed the procedure multiple times during my fellowship. As the patient and family still appeared somewhat skeptical, I encouraged them to seek a second opinion if they would like and to take more time to make their decision. Two days later, I was surprised when the patient called me to say, "Doctor, I would like you to do the procedure as I feel comfortable with you and trust you because you spent a lot of time with me and my family."

As noted in both aforementioned clinical vignettes, effective physician-patient communication is essential to overcome skepticism and build a trusting relationship. The following are the fundamental elements of effective communication in physician/patient encounters: establishing a connection by encouraging the patients to participate in decision making; exploring their beliefs, concerns, and expectations; acknowledging their ideas, feelings, values, and priorities in their lives; using nonmedical terms to explain complicated medical procedures; clarifying and summarizing information; checking for understanding; encouraging questions; and most importantly, maintaining humility while doing all these elements (6–8). Clinical encounters that have these elements are associated with improved patient satisfaction (9,10). Even in the setting of limited time, I believe acknowledging the patient's concerns, as well as the social and emotional situation with empathy using both verbal and nonverbal cues, is invaluable in establishing trust and improving the quality of care and patient satisfaction.

The first year as an attending interventional cardiologist is undoubtedly overwhelming. Adapting to the culture of a new place and dealing with the overall skepticism from patients and coworkers because of our inexperience is challenging. When it gets too overwhelming, it is important to step back and simply focus on patient care. Everything else will fall into place. The transition will be easier and professional satisfaction will be higher if we consistently take time to put in the effort to build trusting relationships with our patients. In the previous clinical vignettes, the only way I was able to overcome the initial skepticism from patients and their families is by taking time to communicate clearly and by demonstrating empathy and humility. When my patient thanked me after successful completion of the percutaneous intervention using rotational atherectomy, I could not help but say, "Thank you for letting me take care of you."

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RESPONSE: Gaining Trust

A Critically Important Mission of All Physicians

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Invasive treatment of acute myocardial infarction is the hallmark of an interventional cardiologist. It is our defining professional skill, and is at the core of our reasons for choosing this field. Few other medical procedures are as urgent, or carry such high stakes, as percutaneous coronary intervention in the setting of acute myocardial infarction. Life-and-death decisions must be made instantaneously, and often, there is little to no time to involve family in the discussion of treatment options, especially when the patient is brought to the emergency room by emergency medical services without family present.

Despite these obvious barriers, as Dr. Mallidi points out, taking a moment to connect and communicate with the patient and his or her family is vitally important for every physician, including interventional cardiologists. Establishing a relationship of trust between the patient and his or her family and the physician caring for them has been shown to result in tangibly improved outcomes for that patient (1), as well as reduced risk of malpractice claims for providers (2). Dr. Mallidi points out the critically important mission that we as physicians have to establish an emotional connection with our patients and their families; our success in achieving such a connection directly correlates with our patients' trust in us, and thus with the likelihood that they will follow our medical advice (3,4).

Dr. Mallidi also addresses the difficulties that young physicians experience when they are starting in practice after finishing their training. Interventional cardiology has one of the longest apprenticeships of any medical specialty; by the time an interventional cardiologist begins practicing, he or she has completed between 7 and 9 years of post-graduate training, with 1 to 3 years spent learning the skills needed to work in the cardiac catheterization laboratory. Despite this prolonged hands-on training, making the transition from fellow to attending physician is difficult. Once the responsibility rests on your shoulders, every decision is harder and every choice you make is rehashed over and over, especially if the outcome is less than perfect. This is made even more difficult when patients and family members question a young physician's experience. As Dr. Mallidi illustrates, the best approach is to be honest and humble. This does not mean that one should underplay one's skills: it is perfectly appropriate to point out that you have done many cases in advanced interventional fellowship, that all procedures in the catheterization laboratory are done as part of an experienced team, and that you are confident that your training prepared you well for the job at hand. As Dr. Kimberly Atianzar, an advanced structural fellow at Swedish Hospital in Seattle, Washington, pointed out in a recent blog post for TCTMD, it is critical for an interventional cardiologist to learn "HOT" communication skills—honest, open, 2-way communication—and the key to doing this successfully is to emulate faculty members who do it well, as well to learn what *not* to do from those who do it poorly (5).

Learning and practicing effective communication skills is at least as important as learning excellent procedural skills; as this post illustrates, a good interventional cardiologist must be able to do both.

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