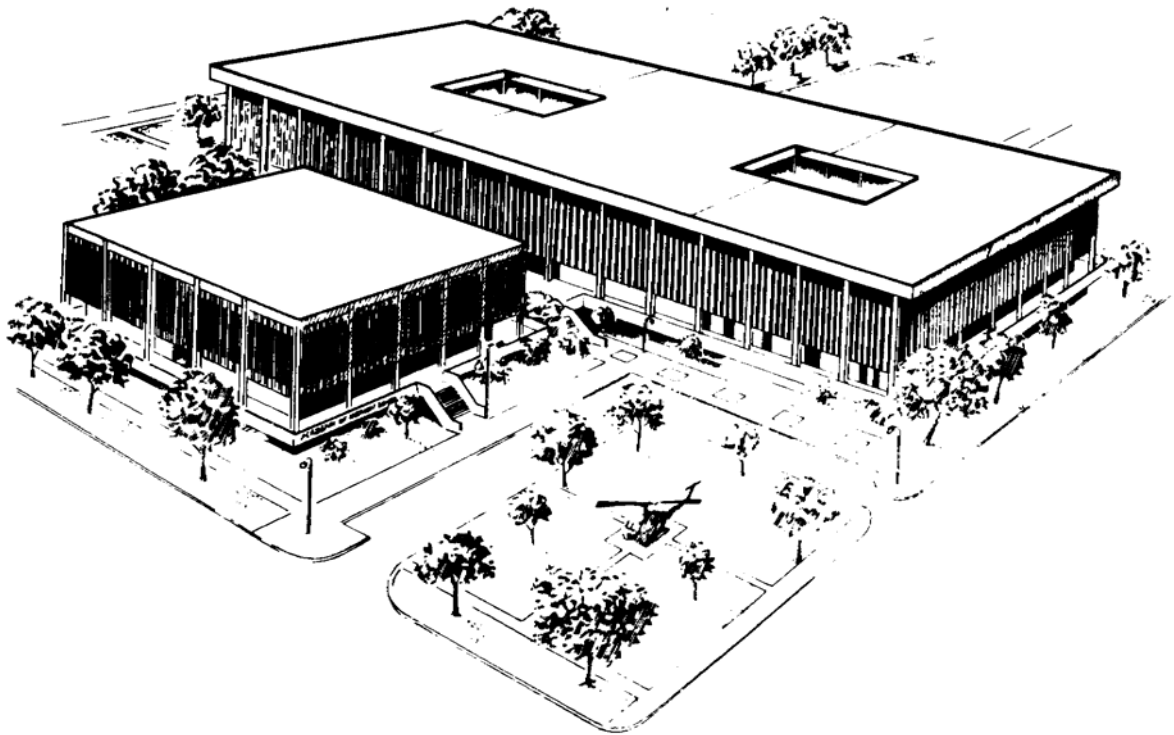

**U.S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
FORT SAM HOUSTON, TEXAS 78234-6100**



**QUALITY OF CARE:
PATIENT RELEATIONS**

SUBCOURSE MD0520

EDITION 100

DEVELOPMENT

This subcourse is approved for resident and correspondence course instruction. It reflects the current thought of the Academy of Health Sciences and conforms to printed Department of the Army doctrine as closely as currently possible. Development and progress render such doctrine continuously subject to change.

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CLARIFICATION OF TRAINING LITERATURE TERMINOLOGY

When used in this publication, words such as "he," "him," "his," and "men" are intended to include both the masculine and feminine genders, unless specifically stated otherwise or when obvious in context.

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**CORRESPONDENCE COURSE OF THE
UNITED STATES ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL**

SUBCOURSE MD0520

QUALITY OF CARE: PATIENT RELATIONS

INTRODUCTION

As medical technology advances at an incredible pace and medical treatment becomes increasingly specialized, many of us seem to be losing sight of another vital aspect of health care--the human aspect. It is becoming increasingly evident that emotional needs play an integral part in the healing process. People want to feel confident in the medical treatment and nursing care they receive and want to be cared for as individuals.

As health care providers, you have tremendous influence on the attitudes of your patients and the people closest to them--their family members and friends. By applying those skills used by all effective practitioners who provide kind and compassionate care, you can help your patients to make the most of the resources they already possess--resources, which will lead them to healing.

Subcourse Components:

This subcourse consists of three lessons:

Lesson 1, Loss and Change.

Lesson 2, Communication.

Lesson 3, Patients' Rights.

Credit Awarded:

Upon successful completion of this subcourse, you will be awarded four credit hours.

LESSON ASSIGNMENT

LESSON 1

Loss and Change.

TEXT ASSIGNMENT

Paragraphs 1-1 through 1-18.

LESSON OBJECTIVES

After completing this lesson, you should be able to:

- 1-1. Describe losses and changes experienced as a result of illness and/or hospitalization.
- 1-2. Name the three major stages of illness.
- 1-3. Define quality medical care.
- 1-4. Define health care provider.
- 1-5. Name the components of a good bedside manner.
- 1-6. Discuss ways to calm an angry health care receiver.
- 1-7. Discuss the impact family members have on patients.
- 1-8. Discuss ways to improve interactions with family member of patients.
- 1-9. Given a description of a situation, select the action a health care provider should take in dealing with a patient.

SUGGESTION

After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 1

LOSS AND CHANGE

Section I. THROUGH THE PATIENT'S EYES

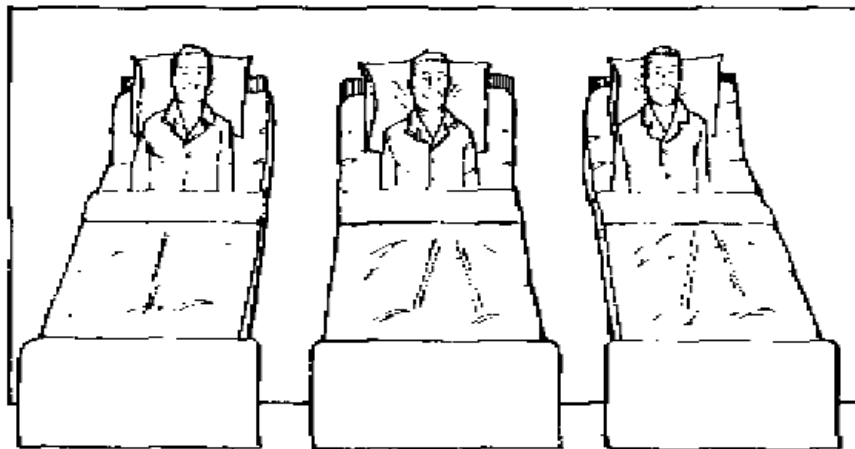
1-1. INTRODUCTION

a. Take a few minutes to sit quietly and imagine yourself as you go through a typical day in your life. Imagine a workday; then imagine a weekend. As you do, jot down all the things that are truly important to you, the things that make you happy.

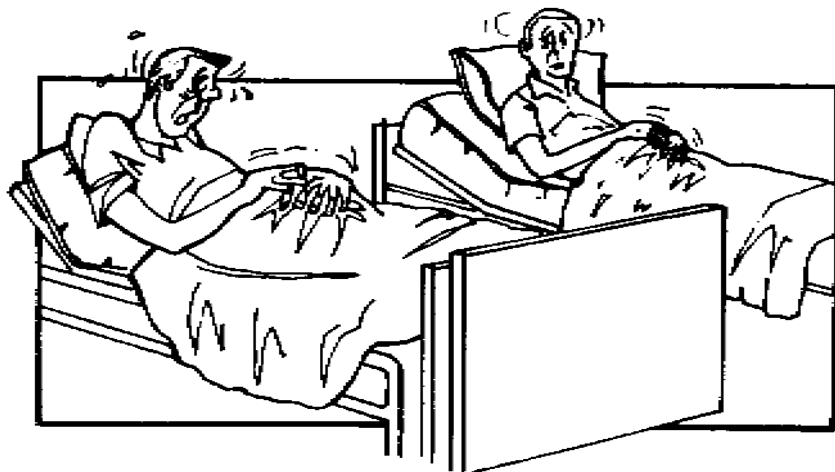
b. Now imagine yourself entering a hospital. Picture everything that happens to you from the time you are admitted to the time you are released. As you do this, cross off of your list all the things that you would lose. If you are like most people, few, if any, items remain. Think about the sense of loss you could be experiencing as a patient. Virtually all control over the things that enable you to feel content and secure have been taken away. Depending on a number of factors affecting your life, you may or may not find it easy to adapt to these changes.

1-2. EXPERIENCING ILLNESS AND HOSPITALIZATION

a. Loss of role identity is one of the things you, as a patient, may experience upon entering the hospital. They take your clothes away and put you in blue pajamas, the same blue pajamas as all the other patients. You are given an identification number. You hear people making rounds referring to you by your illness rather than your name. You hear other health care personnel talking about you in the third person.



b. The next thing you may feel is a loss of privacy. You are probably on a ward or sharing a room with others. Medical personnel walk in and out unannounced, some using you as a training tool. A health care provider examining you may have forgotten to close the door or curtain. Another may not be especially careful to keep you covered. People are requesting information about things you normally keep to yourself. Information concerning your health and treatment is hanging on the end of your bed for anyone to see. You overhear health care providers discussing your case with each other.



c. You may be feeling threatened, frightened, or insecure. After all, you have been taken away from your familiar routine and placed in a strange environment where unusual and often painful procedures are performed, some of which leave you feeling less than dignified.

d. You may have been informed of the name of your condition or disease, but you do not understand exactly how your body is being affected by it. You may have heard your health care providers discussing your illness and treatment, but you do not understand most of what was said. Therefore, you begin to feel unable to participate in your own treatment. You begin to feel helpless and dependent on others, especially if you need help with normally simple things, such as eating and drinking.

e. You may have unmet positive expectations. "I expected to be given something that would cure me, a pill or an operation." "I expected my records to be here." "I expected the medical staff to be as concerned about my symptoms as I am." Or you may have negative expectations confirmed. "I just knew I'd have to wait a long time." "I thought I was in bad physical condition." "I knew I was going to feel humiliated."

f. You may fear serious illness for erroneous reasons. You may have overheard medical personnel discussing your illness, but using terminology, which you did not quite understand, or you may have just thought they were talking about you. You may have heard something that was not meant for your ears when someone

thought you were asleep or unconscious. You might make incorrect assumptions after hearing the patient in the next bed discussing his symptoms, which happen to be very similar to yours.

g. You may feel frustrated or anxious about your care being fragmented. Twenty different staff members may pass through your room on a given day, taking blood, serving food, conducting tests. When you ask one of them a question, you may be referred to another level of authority.

h. You may be experiencing other feelings as well--such things as lack of companionship and loneliness. You are probably worried about your health and how your absence may be affecting your family, job, or financial status. You may fear not being taken seriously, especially in a military environment, where people may be suspected of seeking unnecessary medical attention because it is free.

i. Your patients could be experiencing any or all of these feelings, or they may just be fearful of experiencing them. Some people cope with such changes very easily with no apparent emotional strain and no apparent changes in behavior. Others, for numerous reasons, have a more difficult time coping. If you can see things through your patient's eyes, you can empathize with any emotional strain experienced and you will expect the unusual behavior that sometimes follows.

Section II. STAGES OF ILLNESS

1-3. INTRODUCTION

Possibly no two people respond to illness in the same way. Reactions vary depending on such things as cultural background, past experiences, personality, and upbringing. One person may have been brought up in a family in which expression of discomfort or discontentment was frowned upon, whereas, in another family, loud complaining and whining may have been considered to be acceptable and encouraged. Certain patterns of behavior can be seen, however, in most people, especially those who are seriously ill. Changes in behavior usually coincide with three major stages of illness:

- a. Transition from health to illness.
- b. Acceptance of illness.
- c. Convalescence.

1-4. TRANSITION

a. When a person discovers that he is becoming ill, it is only natural for him to experience anxiety about the events to follow, especially if he suspects that he has a severe illness or one which will result in a long recovery period. There may be many questions on his mind that he cannot answer at this point. Will the illness cause long-term or permanent damage? Will there be a lot of pain--from the illness or the treatment? Is there any possibility of disfigurement or disability? How will the family react?

b. One common response to this anxiety is to deny that the illness exists. A patient may refuse to accept the fact that he is ill and may actually show signs of being in perfectly good health.

1-5. ACCEPTANCE

As the illness progresses, the patient is usually forced to accept the fact that he is ill and must accept treatment. Along with this acceptance, he may begin to lose interest in things that do not involve his health and satisfaction of his needs. If carried to the extreme, he may become totally self-centered, like a child. If his world becomes dominated by thoughts and discussions of his illness, his medications, his temperature, his pulse rate, and so forth, he may be viewed by others as a hypochondriac. Feelings of inadequacy may cause him to become emotionally dependent on others, especially if his illness brought about a physical dependency. Although these personality changes may appear to be anything but healthy, they are common and often necessary responses. They should begin to cease when medical treatment ends or succeeds in reversing the progression of illness.

1-6. CONVALESCENCE

a. The convalescence stage is the period of time it takes the patient to drop these changes in behavior and "become himself" again. The amount of time required for this stage may be prolonged if the patient was unable to work out some of his anxieties while he was in the acceptance stage. He may still be unsure of the severity, duration, or other aspects of his illness. He may find it difficult to regain his independent state due to fear of losing the support of his family and the hospital staff. If he has been hospitalized for a long period of time, he may now view hospital life--the staff, the other patients, the routine--as being comforting and satisfying.

b. Again, different people respond to illness in different ways. One person may go through all the stages just discussed; another, through none of them; a third may experience them, but in a different order from the first.

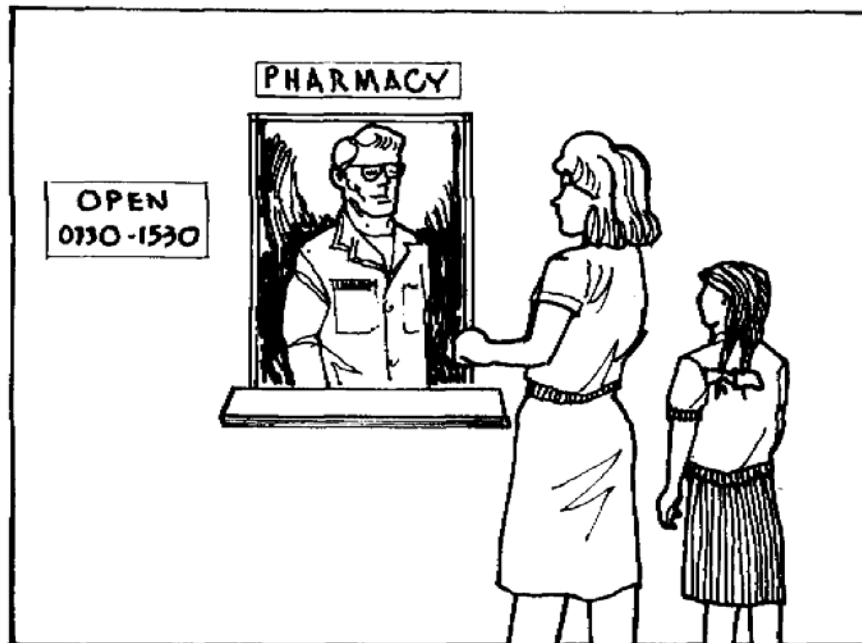
Section III. BEDSIDE MANNER

1-7. INTRODUCTION

In a medical world dominated by sophisticated technology and specialization of medical treatment and training, it is no wonder that the human aspect of medical care is often neglected. As health care becomes more sophisticated and specialized, many health care providers tend to become extremely task-oriented, focusing in on the illness rather than the person who is ill. As a result, many patients have emotional needs that are never met. The body and the mind are both integral parts of the healing process. One cannot be stressed to the exclusion of the other.

1-8. DEFINING HEALTH CARE PROVIDER

Regardless of your MOS, if you have any type of contact with a patient or his family and friends, you have an influence on that patient's well being. Your presence in itself can affect a patient's mood. Since different patients seek information from different sources, patients often save their questions for health care providers with whom they feel comfortable or with whom they can identify. Whether your relationship with the patient is as an entry-level medic, a practical nurse, a professional nurse, a doctor, a pharmacy technician, or a receptionist, you have an effect on his recovery. For purposes of this subcourse, you can consider yourself to be a health care provider if you have any type of contact with a patient or his family and friends.



1-9. BEING PROFESSIONAL

Being professional does not mean acting aloof or rigid. This simply means that you abide by certain obligations, which are inherent in your job. Some of these obligations are given below.

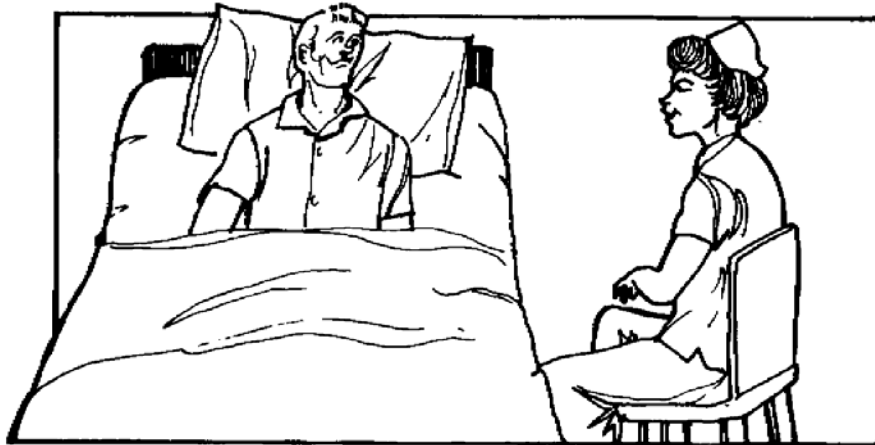
- a. Set aside your needs for the needs of your patient. This is an unequal relationship; it is not reciprocal, as in a social relationship in which you try to do things for each other on a relatively equal basis. The patient's needs come first.
- b. Have an open, nonjudgmental attitude toward your patients. Unlike a social relationship in which you may choose to reject a person or a person's ideas, you must be completely accepting of your patient's thoughts and feelings.
- c. Avoid taking advantage of your position. Your role as a health care provider may, in many ways, be perceived as one of authority or superiority over your patients. As a professional, you will never abuse that power.
- d. Consider information regarding a patient's medical history, diagnosis, treatment, and prescribed medications to be strictly confidential. This information should be available only to those who have an authorized need to know.

1-10. DEVELOPING A THERAPEUTIC BEDSIDE MANNER

There are many negative aspects of illness over which you, as a health care provider, have no control. You can, however, help to make the experience more tolerable and decrease recovery time by developing a therapeutic "bedside manner." Unfortunately, the best intentions are often lost among crowded conditions, long hours, and busy schedules. But the time seems well spent when you consider the impact interpersonal relations have on the healing process. Therapeutic interpersonal relations between the patient and the health care providers lead to greater patient satisfaction. A satisfied patient will have a more positive outlook, will pay more attention to what medical and nursing personnel tell him, will believe what they tell him, and will become more involved in his own health, treatment, and care. Consider the following points in developing/improving your "bedside manner."

- a. First of all, a smile and a warm greeting can work wonders for lifting spirits.
- b. Speak in a pleasant tone and look the patient in the eyes during conversations.
- c. Beware of the importance of common courtesy. Be polite, even if the patient is not. Remember, he is experiencing a lot of stress and may not be on his best behavior. But the worst behavior is often an indication of the greatest need for compassion.

- d. Call the person by name, but never just the last name. Use the appropriate rank or customary title whenever possible (Colonel Johnson, Mr. Jones, Ms. Smith).
- e. Show respect and genuine concern.
- f. Establish trust by being honest, reliable, and considerate.
- g. Avoid speaking to the patient from the doorway. A few minutes spent sitting at the patient's bedside is generally perceived by the patient to be much longer than the same amount of time spent standing in the doorway.



- h. Explain procedures and directions in a calm and clear manner. If the patient is nervous or preoccupied, it may be necessary to repeat them. Before tests and treatments begin, the patient should be told by an authorized individual why the tests and treatments have been ordered and what to expect. If medication has been prescribed, the patient should be informed of its purpose and instructions regarding its use.
- i. If authorized, be generous with information about the patient's illness, especially if he is asking questions. If he understands what his problem is, the chances of his becoming more involved with his own treatment are greater. If you are not authorized to give out the information requested, find someone who is.
- j. Encourage the patient to express his feelings, needs, and desires.
- k. Provide the patient with as much privacy as possible. Always remember to close the door or curtain during examinations and keep the patient covered whenever possible.

l. Be professional and display confidence in yourself and your abilities. The patient will have more confidence in you if he can sense that you have confidence in yourself.

m. Take coffee breaks out of the patient's sight.

n. Give the patient reasons for inconveniences. If he has to wait an hour to get into the clinic, or if someone who came in after he did had to be taken first, politely tell him why. And do not take it personally if he is easily angered by such inconveniences.

Section IV. THE ANGRY PATIENT

1-11. CAUSES OF ANGER

In addition to biological needs (for water, food, etc.), human beings have needs that are on a higher level. These include such things as self-esteem, identity, reputation, a feeling of belonging, a sense of accomplishment, and a feeling of control over one's life. Needs of the second type often go unmet during periods of illness, incapacitation, and/or hospitalization. These unmet needs, along with other losses and threatening experiences, often lead to frustration and then anger (often for the family members as well as the patient). To make matters worse, the patient's usual ways of coping with anger are not available to him. He cannot run around the block or play tennis. Also, he may not feel free to express his anger, especially if he is trying to be a "good patient." (The patient trying too hard to be cooperative and do what he is told without asking questions may be increasing his level of stress and, thereby, his recovery time.)



1-12. SYMPTOMS OF ANGER

Anger can take many different forms. One patient may express his anger by becoming aggressive or abusive. Another may turn his anger inward and become lethargic and indifferent. Still another may act childish or complain and criticize everything and everyone around him.

1-13. DEALING WITH AN ANGRY PATIENT

In spite of the best “bedside manner,” there is sometimes little you can do to prevent anger. For many people, it is a natural response to illness. In these situations, consider the following things to aid you in dealing appropriately with an angry patient or family member. Keep in mind that you cannot expect everything to work every time. Just use good judgment before responding. You can usually sense to what extent the patient wants your involvement.

- a. When you encounter an angry patient, you should not take it personally. Remember that anger is a common response to anxiety, fear, or frustration. This may keep you from becoming angry yourself and passing it on--to that patient, other patients, or other health care personnel. Remember--anger is contagious.
- b. If there is a particular problem or misunderstanding, respond as early as possible by providing information or advice that could clear things up.
- c. Express genuine concern for the patient's feelings.
- d. It is often helpful to acknowledge the patient's feelings. Otherwise, he may feel the need to continue to display his anger until someone recognizes it. And if he does, he may be too upset to hear anything you are telling him. Just a simple statement such as, “I can see you're upset,” or, “I know you're not very happy about this,” should be sufficient. Remember, the expression of concern is more important here than the choice of words. (See “Nonverbal Communication,” paragraphs 2-5 through 2-7.)
- e. Before approaching the patient, you may feel the need to give him time “to cool off.” When you sense the time is right, sit down with him and listen patiently. He may need to tell you why he is angry. Or he may need to talk in order to determine the source of his anger.
- f. You may avoid intensifying the anger by “softening” your statements using “I” rather than “you.” “I'd like for you to get some exercise, ”generally receives a better response than “You really need to exercise.” “I'd rather you didn't do that,” is easier to swallow than “You shouldn't do that,” or “Don't do that.”
- g. When appropriate, you may be able to suggest particular activities to help the patient work out his anger.

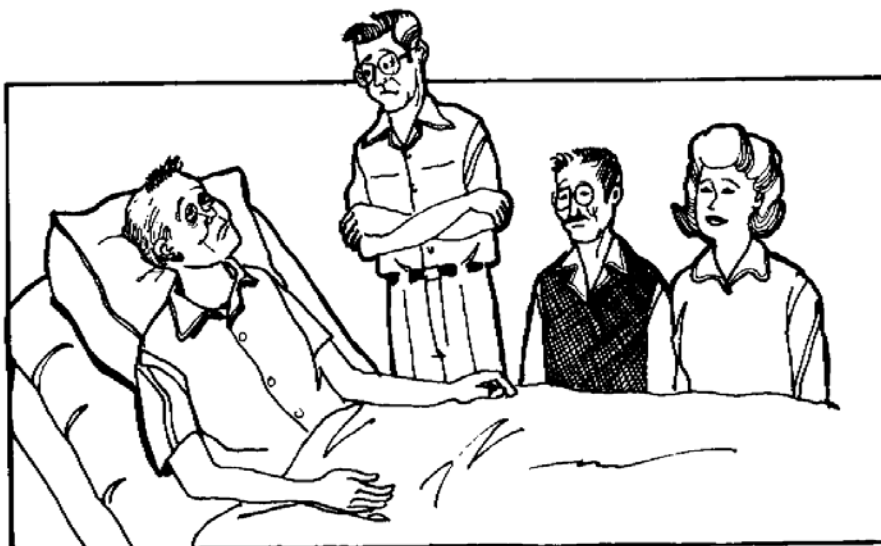
h. If you feel that your own anger is a problem, learn to control it. You may have no control over anger-provoking situations, but you do have control over your emotional and behavioral responses to such events. Monitor yourself. Pay close attention to the thoughts that you have in response to these events. The things you say to yourself may be causing you to become angry. Learn to control what you say to yourself and you can learn to control your emotional responses to external events.

Section V. FAMILY MEMBERS

1-14. INTRODUCTION

a. Illness and/or hospitalization of one family member places stress on the entire family unit. Members of a patient's family often have the same worries as the patient. They may be concerned about such things as the severity of the illness or the financial burdens of hospitalization. They may feel angry or helpless. They may have unmet positive expectations, confirmed negative expectations, or unnecessary fear due to erroneous or incomplete information. In addition, they may have feelings of guilt or blame.

b. The interactions a patient has with his family and/or close friends usually have a tremendous influence on his attitude about his illness. Positive or negative feelings, optimism or pessimism, are usually contagious among close family members. Health care providers must keep this in mind when dealing with family members.



1-15. DEGREE OF CONCERN

Of course, closeness of family members and the ability to deal with illness within the family varies. Most are appropriately concerned. Extremes in either direction (under-concern and over-concern) can have a destructive effect on the well being of the patient. For example, if the family is denying the severity of the illness, the patient may wonder about his ability to view things realistically or he may not feel the need to accept proper treatment. If, on the other hand, the family is drastically overly concerned, the patient may begin to think the medical personnel are hiding something from him. If the family, patient, and medical staff respond in different ways, additional anxiety, fear, or guilt may result.

1-16. DEGREE OF HOPE

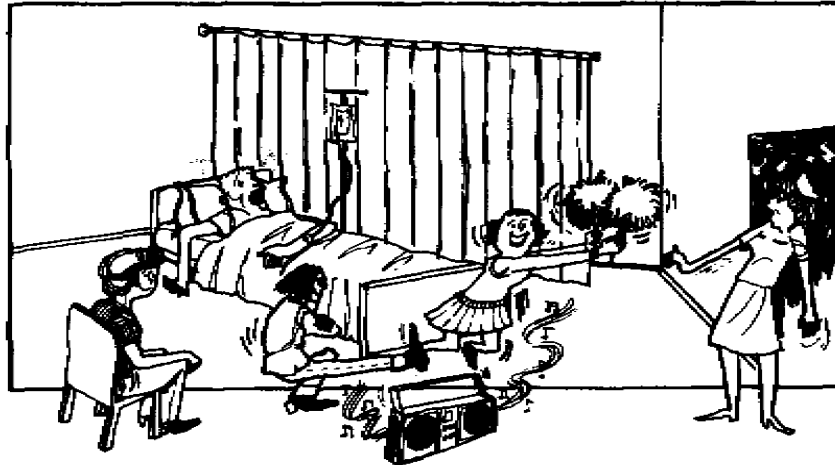
The degree of hope among family members also affects the patient's degree of hope. Time spent by the health care provider with family members helping to develop trust and understanding generally leads to a greater degree of confidence and hopefulness. Medical and nursing personnel can provide support by allowing family members to openly express their needs and feelings. Active listening can help to assure them that their anxious behavior or fear is understood and accepted. (See "Active Listening," paragraph 2-4.)

1-17. BEDSIDE MANNER

a. Explanations of treatments, procedures, and equipment help to calm anxiety and guilt. Remember that if family members are especially nervous, explanations may have to be repeated or simplified. Keep them informed as things progress or change. Explain why unexpected tests have been ordered and what they will involve. Do not take it personally if they feel more secure asking for a second or third opinion.

b. Encourage family participation in the patient's care. If they are doing a good job, let them know. Health care professionals must also take special care to provide the same courtesies (smiles, greetings, calling by name, demonstration of concern, etc.) to the family that they would to the patient. (See "Developing a Therapeutic Bedside Manner," paragraph 1-10.)

c. In hospitals, there are many rules and regulations (visiting hours, number of visitors, age of visitors, food and beverage restrictions, etc.) that were set up for particular reasons, which may not be readily apparent. If you need to enforce these with the family, explain why. Generally, people are reasonable when they understand that there is a real need for the enforcement of a rule.



1-18. FIRST VISITS TO HOSPITALIZED FAMILY MEMBERS

Some people find the first visit to a hospitalized family member (especially one with a severe illness) to be extremely difficult. If a family member appears to be especially nervous or uncomfortable about his first visit, there are things you might do to help. But you must remember to use good judgment. If you sense that the family member wants privacy, leave him alone. But if he appears to want help, and if you feel you can be discreet, consider some of the following as possibilities.

- a. Go into the patient's room with the family member for a few moments just to get conversation started.
- b. Demonstrate that it is okay to touch the patient by holding his hand or touching his arm.
- c. If the patient is unable to speak, consider providing him with pencil and paper for writing.
- d. Consider allowing family members to perform small tasks to make them feel less helpless and fearful (for example, combing the patient's hair, rubbing his back, helping him with a meal).

Continue with Exercises

EXERCISES, LESSON 1

INSTRUCTIONS: Answer the following exercises by marking the lettered response that best answers the question or best completes the statement or by writing your answer in the space provided.

After you have completed these exercises, turn to “Solutions to Exercises” at the end of the lesson and check your answers.

1. When a patient believes that he looks like all the other patients and is thought of as a number or a case rather than an individual, he may experience a loss of _____.
2. A patient in a hospital is upset because he overheard a health care provider discussing his case with a friend. He feels he has lost his right to _____.
3. The three major stages of illness are transition from health to illness, acceptance of illness, and _____.
4. In the transition stage, patients generally experience _____ because of all the “unknowns.”
5. When a patient begins to lose interest in things that do not involve his health, he is experiencing the _____ stage of illness.
6. The time required for the patient to regain his normal behavior after an illness is the _____ stage.
7. When a health care provider puts all his emphasis on a patient's illness rather than looking at the patient as a whole, that patient may have unmet _____ needs.

8. If you have any type of contact with a patient or his family, you:
 - a. Should limit the amount of time taken to an absolute minimum.
 - b. Should have a specific medical need to be there.
 - c. Are qualified to give medical advice.
 - d. Can consider yourself to be a health care provider.

9. As a professional, you should do all of the following EXCEPT:
 - a. Demand respect by maintaining a serious facial expression.
 - b. Consider a patient's medical information to be confidential.
 - c. Set your needs aside for the needs of the patient.
 - d. Have an open, nonjudgmental attitude towards your patients.

10. As a health care provider, you can help to keep your patient satisfied by developing a therapeutic _____.

11. A satisfied patient will generally experience all of the following EXCEPT:
 - a. A more positive outlook.
 - b. A belief in what his health care professionals tell him.
 - c. More personal involvement in his own health and treatment.
 - d. A greater emotional dependency on his health care professionals.

12. When you walk into a patient's hospital room, you should _____ and greet the patient.

13. Whenever possible, call the patient by name, and use the appropriate title or _____.

14. By being honest, reliable, and considerate, you can establish _____ with patients.
15. Before a _____ begins, an authorized individual should let the patient know what to expect.
16. When a person is ill and/or hospitalized, the threatening experiences, losses, and unmet needs often lead to frustration and then _____.
17. Different people respond differently to anger. One may become aggressive or abusive. Another may turn his anger _____.
18. You are a health care provider and Mrs. Miller is your patient. As you enter her hospital room, you smile and ask how she is doing. She responds by saying, "What do you care?" as she folds her arms angrily. You should:
 - a. Pretend you do not notice that she is angry and go on with your work.
 - b. Leave immediately and arrange for another health care provider to care for her.
 - c. Acknowledge her anger and listen patiently to her problem.
 - d. Tell her that you will send your supervisor in immediately.
19. You can often help an angry patient by sitting down with him and _____ patiently.
20. When dealing with an angry patient, it is helpful to:
 - a. Avoid taking it personally and becoming angry yourself.
 - b. Have the patient put his complaint in writing.
 - c. Pretend you do not notice that he is angry.
 - d. Avoid any contact with the patient until he is no longer angry.

21. If a patient's family members are denying the severity of the illness, the patient may not feel the need to accept proper _____.
22. To increase the confidence and hopefulness of a patient's family members, you should:
- Try to do most of the talking when you are with them.
 - Spend time with them in order to develop trust and understanding.
 - Avoid discussions about the patient's illness and/or treatment.
 - Strongly discourage them from seeking another health care professional's opinion.
23. Provide the same courtesies to the patient's family that you would to the _____.
24. When possible, you may allow a patient's family members to perform small _____ to make them feel less helpless and fearful.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 1

On exercise in which you wrote your own answer, the solution provided below may not be the only acceptable solution. If your answer has the same meaning as the one provided, consider it correct.

1. Identity (or role identity) (para 1-2a)
2. Privacy (para 1-2b)
3. Convalescence (para 1-3)
4. Anxiety para 1-4)
5. Acceptance (para 1-5)
6. Convalescence (para 1-6a)
7. Emotional (para 1-7)
8. d (para 1-8)
9. a (para 1-9).
10. Bedside manner (para 1-10)
11. d (para 1-10)
12. Smile (para 1-10a)
13. Rank (para 1-10d)
14. Trust (para 1-10f)
15. Test (or treatment) (para 1-10h)
16. Anger (para 1-11)
17. Inward (para 1-12)
18. c (paras 1-13d, e)
19. Listening (para 1-13e)

20. a (para 1-13a)
21. Treatment (para 1-15)
22. b (para 1-16)
23. Patient (para 1-17b)
24. Tasks (or jobs) (para 1-18d)

END OF LESSON 1

LESSON ASSIGNMENT

LESSON 2

Communication.

TEXT ASSIGNMENT

Paragraph 2-1 through 2-9.

LESSON OBJECTIVES

After completing this lesson, you should be able to:

- 2-1. Define communication
- 2-2. Discuss the importance of communication in the health care setting.
- 2-3. List the reasons people fail to listen to others.
- 2-5. Name several forms of nonverbal communication.
- 2-6. Discuss the importance of nonverbal communication in the health care setting.
- 2-7. Recognize inconsistencies between verbal and nonverbal messages.
- 2-8. Recognize that nonverbal messages can be easily misinterpreted.
- 2-9. Name the components of a successful interview.
- 2-10. Given a description of a situation, select the action a health care provider should take in dealing with a patient.

SUGGESTION

After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 2

COMMUNICATION

Section I. INTRODUCTION

2-1. DEFINING COMMUNICATION

a. If you were to ask ten people to define the word “communication,” you might get ten different definitions. Some people believe that talking is communicating. Yet we have all seen examples of people who can talk to each other for hours without exchanging a bit of meaningful information. We have also seen people who seem to relate beautifully to each other's feelings without uttering a word.

b. Talking is one way of communicating, but there are other, probably more critical, requirements for achieving effective communication. You can speak beautifully on a particular subject, covering every important aspect of that subject, but if the person to whom you are speaking is not listening, are you communicating? Or if that person hears every word you say, but, as you speak, you notice an expression of doubt or confusion coming over his face, can you feel sure he received the message you were trying to convey? Communication has taken place only if the message you wanted to send has been accurately received.

2-2. COMMUNICATION IN THE HEALTH CARE SETTING

As a health care provider, you must keep in mind that the quality of care you provide is, in many ways, dependent on the quality of the communication that exists between you and your patient. Through your direct contact, the patient must perceive your intentions of support and your positive expectations. You must accurately assess the patient's emotional symptoms and, depending upon your particular role, the physical symptoms.

Section II. LISTENING SKILLS

2-3. ARE YOU LISTENING?

a. We have all, at some point(s) in our lives, experienced being ignored. Try to recall a particular situation in which you were speaking but the “listener” was not quite listening. He may have been pretending to listen, nodding at all the appropriate times, looking into your eyes as you spoke, but you knew he was not really listening. How did you feel about this experience--angry, hurt, indifferent?



b. Now try to recall a situation in which someone else was speaking, and you were only pretending to listen. Were you trying to think about something else? Were you intentionally ignoring the speaker? Probably not. Most people, from time to time, will let their minds wander while others are talking. Some of the more common reasons are:

- (1) They may be distracted by important things on their minds.
- (2) They may be unable to concentrate due to nervousness, anxiety, or fear.
- (3) They may simply be “tired” of listening. Most people must spend a large percentage of their waking hours listening. So, at times, their minds drift (often unintentionally) for a little while.

c. However, there are people who make a habit of being poor listeners. Some of the more common examples of chronic non-listeners are listed below:

- (1) People who are so anxious to express their own ideas that they do not listen to what others have to say.
- (2) People who only listen to things that really interest them.
- (3) People who only want to hear pleasant things.
- (4) People who take everything they hear as a threat.
- (5) People who listen to everything in order to collect information with which to later attack what was said.

(6) People who are unable to understand hidden meanings and take words at their face value.

d. Again, everyone occasionally lets his mind wander when he should be listening. As a health care provider, you cannot assume that everything you say will be heard and understood. A patient (or a family member of a patient) who is especially tired or nervous may not initially comprehend instructions or explanations. You must be prepared to patiently repeat things if you suspect that they were not understood.

e. As a health care provider, you must also be aware of your own listening habits. Becoming a good listener takes concentration, effort, and practice, but you can improve your listening skills if you work at it.

2-4. ACTIVE LISTENING

If a patient is seeking information or needs a direct answer to a medical question, you can normally answer him or obtain the answer for him. But there are occasions when you must guide him in finding his own solution. For example, if a patient comes to you with a personal problem, you may be tempted to offer suggestions or encouragement. But, often, the most helpful thing you can do is to be a good listener and to show concern. By doing so, you enable the patient to come to his own conclusions. As you study the following components of active listening, think about your own listening habits.

a. Look the patient in the eyes as he talks.

b. As you listen patiently, concentrate on what is being said. By giving the patient your full attention, not only are you hearing more, but you are also communicating to him that he is not alone, that you are there to think this problem through with him.

c. As the patient speaks, think about what he must be feeling. Sometimes, as a listener, you must cut through layers of words to get to the real message. You must concentrate not only on the words, but the hidden meanings behind them. Look at the following hypothetical statements from patients, and imagine what they might have been feeling as they spoke.

(1) “What a coincidence! That man they just took off to the operating room had a pain in his side too!”

(I'm afraid I have the same problem.)

(2) “Gee, I guess you get pretty tired of all the people who come in for treatment just because it's free.”

(I'm afraid you're not taking my illness seriously.)



(3) “Normally I pride myself on being self-sufficient in my work and in my private life.”

(I'm embarrassed about feeling dependent and helpless like a child.)

d. Do not interrupt the patient in the middle of a thought.

e. Make an occasional brief response such as a nod or a short comment that implies that you understand (for example, “I see,” “Uh-huh,” “Right”).

f. Occasionally repeat (in your own words) what the patient said.

(1) An example might be:

PATIENT: I didn't eat lunch or dinner today.

HEALTH CARE PROVIDER: You haven't had much of an appetite.

PATIENT: No. I keep thinking about all the things that must be piling up at the office.

HEALTH CARE PROVIDER: I see.

(2) By giving the message back to the speaker (but in your own words), you are letting him know that you are listening, comprehending, accepting, and interested. If he feels you truly understand and accept his problem as being valid, he will be encouraged to continue to “open up” to you and to listen to your advice. By accepting

his problem as being valid, you are not necessarily agreeing with him or implying that you would respond in the same manner. You are simply communicating to him that you consider his feelings to be normal and reasonable.

g. Ask questions if you do not understand something being said or as another way of encouraging the speaker to continue. An example might be:

PATIENT: I don't want to take these pills today!

HEALTH CARE PROVIDER: Are you getting tired of taking pills?

h. Consider carefully before attempting to reassure the patient by denying that a problem exists.

(1) For example:

PATIENT: I'm really worried about my surgery tomorrow.

HEALTH CARE PROVIDER: Why? You have the best surgeon available, and it's just a minor operation.

(2) This is a common and well-intentioned type of response to verbalization of a problem. However, in some cases, it may embarrass the patient or cause him to question his own ability to view things realistically. This type of reassuring comment is one of the many responses you may choose to give. But any response should be given only after you:

(a) Establish the fact that you understand and accept the problem as being valid.

(b) Explore the problem by encouraging the patient to elaborate. In this way, you can get a better understanding of his thoughts so that you can choose an appropriate response.

(3) Compare the following interaction to that above.

PATIENT: I'm really worried about my surgery tomorrow.

HEALTH CARE PROVIDER: It's really bothering you?

PATIENT: Yes. I just can't get it off my mind.

HEALTH CARE PROVIDER: Is there anything in particular that you're worried about?

PATIENT: I'm concerned about being put to sleep.

HEALTH CARE PROVIDER: Yes, it can be frightening turning your life over to others. However, you'll have an exceptional surgical team, including a highly qualified anesthetist watching you throughout the entire operation.

Section III. NONVERBAL COMMUNICATION

2-5. ACTIONS SPEAK LOUDER THAN WORDS

a. If you want to get a true picture of a person's feelings, do you focus in on what he is saying or how he is saying it? Both are certainly important factors, but nonverbal clues often give a more accurate "picture" of a person's feelings than his words alone, especially if he is trying to hide something. For example, think about the following nonverbal messages and what they might reveal about a person.

- (1) Facial expression (smile, frown, blank look, grimace).
- (2) Gestures/mannerisms (fidgeting, toe tapping, clenched fists).
- (3) Eye behaviors (avoiding eye contact, staring, wide eyes).
- (4) Posture (erect, slouching, leaning toward/away from someone).
- (5) Voice (sarcastic, stammering, shaky).
- (6) Interpersonal distance (how far a person sits/stands from another).
- (7) Use (or avoidance) of touch.
- (8) Appearance (face, hair, body, clothing).
- (9) Environment (office, desk, car, house, room).

b. These signals may tell you whether a person is relaxed or tense, concerned or indifferent, friendly or distant, happy or sad, confident or unsure of himself, serious or joking. They might tell you that he is embarrassed, afraid, or angry. By paying close attention to the nonverbal messages another person sends out, you can learn a lot about that person's feelings. By paying attention to the messages you send out, you



can get a better idea of how other people may be “reading” you. In fact, when you come into contact with another person, it is quite difficult, if not impossible, to avoid communication altogether. Everything you do (or fail to do) says something about you. Look at yourself right now. If someone were watching you, what kind of messages would he be receiving? What clues would he be picking up about your feelings?

c. Nonverbal communication is a vital part of health care. Because of the fears and anxieties many patients are experiencing, chances are they will be especially sensitive to nonverbal signs. And people trying to be “good patients” would rather rely on these signs than ask questions. A smile or warm expression might communicate genuine concern. A harsh look or quick pace could make the patient feel the medical provider is too busy for him. A certain stare or glance could bring on a negative interpretation, whereas failure to look the patient in the eye at all can make him feel less than human. You already know what the signs can imply about you. So pay close attention to what you are “telling” people.

d. Likewise, health care providers cannot depend on words alone to get an adequate picture of the patient's symptoms and feelings. Facial expression can provide an indication of intensity of pain. From the tone of the patient's voice, the provider can sense fear, anger, sadness, joy, or pain. Squirming, pacing, or tapping generally imply restlessness, etc. Some patients may feel embarrassed or uncomfortable expressing their feelings verbally due to a number of possible factors, such as upbringing, cultural background, past experiences, or personality. But they often cannot avoid or are not aware of nonverbal expressions.

2-6. INCONSISTENCIES BETWEEN VERBAL AND NONVERBAL MESSAGES



a. There are times when a person's actions are not consistent with his words. Although they may not always be as obvious as in the example above, contradictory messages are common, especially in a hospital setting, where family members and friends often try to "protect" one another. It is not uncommon, for example, to hear a patient's family member saying, "You look fine," with a shaky voice, or to hear a patient telling a family member, "I'm feeling just fine," as he quickly looks away. Many patients, for one reason or another, want to "put up a good front." You might have a patient who, upon being asked whether he is experiencing pain during a particular test, says "No" through his clenched teeth or, upon being asked whether he is nervous about his upcoming surgery, says "No" as he paces the floor. By being attentive to these signs, you can learn quite a bit about a patient's needs, things that he may feel uncomfortable verbalizing.

b. In the same way, you must be aware of the degree of consistency between your verbal and nonverbal messages. As we discussed previously, patients are often especially watchful for clues as to the nature or severity of their illnesses. Some may suspect that you, as a health care provider, are trying to protect them from the truth or keep them from being alarmed. So you must be sure that your nonverbal behavior is consistent with your words. If you say, "Your tests look fine," with a frown on your face, will the patient believe your words? And if he does, will he wonder how pleased you are about the good news? If you ask how your patient is doing without looking up from your paperwork, will he assume from your words that you are truly concerned about his condition?

2-7. MISINTERPRETATIONS OF NONVERBAL MESSAGES

a. Although nonverbal communication can be very revealing, it can also be easily misinterpreted. Consider the following situations.

(1) You are talking to a patient and he yawns. What goes through your mind? Do you think he is bored? Did he not sleep well last night? Did he eat too much at lunchtime? Maybe your interpretation depends to some extent on your mood or how you slept the night before.

(2) Your patient is slumped over in his chair. Do you wonder if he is unhappy about something? Is he tired? Does he have naturally poor posture? Is he not feeling well? Is he lacking self-confidence? Is he relaxed?

(3) You are a patient and your health care provider comes in looking grim and silent. Do you assume he is just having a bad day? Does he dislike you? Does he dislike his job? Is your condition much worse than he had suspected?

b. Interpretation of nonverbal communication is also complicated by the fact that the same act can have several different meanings, depending on a person's cultural, religious, or family background. Some examples are listed below.

(1) In some cultures, it is natural and polite to look directly into the eyes of the person with whom you are communicating. In others, it may be interpreted as being improper or disrespectful, especially when speaking to a person of authority.

(2) In some families, kissing, embracing, and holding hands are normal and encouraged behavior. In others, these behaviors are rarely practiced and may be perceived as being annoying or offensive.

(3) To one person, standing a foot away from someone else during a conversation may be a perfectly comfortable distance. For another person, that same distance may feel so close and invading that he is distracted from what is being said.



c. As you know, some people are more expressive than others. And some nonverbal clues are easier to interpret than others. But, by remaining alert and sensitive to the signals other people emit, you can improve your ability to interpret feelings. (When unsure, you can often clarify your interpretations through verbal means.) By observing your own nonverbal signs, you can become more aware of the messages people are receiving from you. Whether “reading” someone else or “being read,” it is important to remember that nonverbal messages are clues to a person's feelings, not facts.

Section IV. INTERVIEWING TECHNIQUES

2-8. DEFINING INTERVIEW

The definition of the word “interview” varies depending on the setting, the nature of the discussion, etc. As a health care provider, you may be requesting medical information about a patient (from the patient himself or from his family members) or you may be providing medical information to a patient and/or his family. In any case, for our purposes in this subcourse, you can consider a conversation to be an interview if the following conditions exist.

- a. The discussion is of a professional nature.
- b. You plan the conversation in advance.
- c. You have a specific objective or purpose for the meeting.
- d. Information is being exchanged.

2-9. CONDUCTING A SUCCESSFUL INTERVIEW

The success of the interview will be determined by a number of factors, some of which are beyond your control. You cannot assume that the person/people you are interviewing [interviewee(s)] will be receptive or cooperative. You cannot force them to answer openly and in sufficient detail. But the following hints should assist you in creating an atmosphere, which will encourage such attitudes.

- a. Before the interview begins, obtain as much information as possible (and as allowed) about the patient's history.
- b. To the extent possible, determine the information needed before the meeting begins. This should keep the interview moving smoothly and in the proper direction.
- c. Find a comfortable and quiet place to conduct the interview.

d. Face the interviewee and look him in the eyes. Greet him and, if appropriate, ask him to be seated.

e. If you tend to lean, lean toward, rather than away from, the interviewee. And remain alert to your other nonverbal signs. (See “Nonverbal Communication,” paragraphs 2-5 through 2-7.)

f. Introduce yourself (by name and title).

g. Assure the interviewee that only people with a need to know will be given the information he releases.

h. Discuss the purpose/goals of the interview.

i. Explain how the information you receive will be used or why the information is needed. The seeking of personal or confidential information may be interpreted as being nosy or meddlesome. If the interviewee understands that you need the information for a specific purpose that may benefit him or someone he cares about, he is likely to have greater confidence in you. He may still feel embarrassed or uncomfortable about revealing private information, but he is less likely to feel threatened or to resent you after the interview is over.

j. If you want or need to take notes, get the interviewee's permission. And let him know why you need to take notes. This may reduce any inhibiting effects. Also try to keep the number of words written to a minimum.

k. Let the interviewee do most of the talking, and be a good listener. (See “Listening Skills,” pages 2-2 through 2-4.)

l. Avoid using technical words which could be misunderstood.

m. Avoid putting words in the interviewee's mouth. That is, avoid asking questions that suggest or encourage a particular answer (for example, “I suppose you're feeling rested after your nap,” rather than “How are you feeling?”).

n. Avoid making value judgments. If the interviewee feels that you are looking down on him, he is less likely to “open up” to you.

o. Plan the type of questions you ask according to the type of answers you are seeking. If you want short, straight answers, ask questions which will allow only for a direct response (for example., “Do you have pain after eating?” or “When was your accident?”). On the other hand, if you want to encourage the interviewee to speak freely, use open-ended questions, those which cannot easily be answered with a yes, no, or short answer (for example, “How are you coping with your illness?” or “Can you tell me what is bothering you?”).

p. Ask only one question at a time, allowing for a response after each question. Avoid asking questions, which may be difficult to remember in their entirety (for example, “Would you say the pain has been constant, intermittent, has occurred about once a day, or has occurred only once or twice in all?”). Avoid asking two-part questions in which, by the time the interviewee has answered the first part, he may have forgotten the second part (for example, “How did the accident happen, and can you describe the pain you have experienced as a result?”).

q. Close the interview with a brief summary or review of what took place. Ask the interviewee if there is anything he would like to add or if he has any questions. Let him know of any follow-up activities that might be taking place. If you wish, you may want to invite the interviewee to contact you if he has any further questions. And, of course, thank him for his cooperation.

Continue with Exercises

EXERCISES, LESSON 2

INSTRUCTIONS: Answer the following exercises by marking the lettered response that best answers the question or best completes the statement or by writing your answer in the space provided.

After you have completed these exercises, turn to “Solutions to Exercises” at the end of the lesson and check your answers.

1. Effective communication takes place only when the message transmitted is accurately _____.
2. Through your patient's direct contact with you, he must perceive your intentions of support and your positive _____.
3. Through your direct contact with your patient, you must accurately assess his physical and emotional _____.
4. Most people fail to listen from time to time because they are “tired” of listening or because of important things that are _____ them.
5. Being an active listener involves all of the following EXCEPT:
 - a. Concentrating on what is being said.
 - b. Thinking about the hidden meanings behind the words.
 - c. Avoiding asking questions about what was said.
 - d. Making an occasional brief response or comment.
6. To be an active listener, you must not _____ the speaker in the middle of a thought.,
7. To get an accurate interpretation of a patient's feelings, you must pay attention not only to what he says but _____ he says it.

8. All of the following are forms of nonverbal communication EXCEPT:
- a. Words spoken.
 - b. Posture.
 - c. Interpersonal distance.
 - d. Appearance.
9. People trying to be “good patients” often rely on _____ signs rather than ask questions.
10. Mrs. Johnson's physical therapist is helping Mrs. Johnson with her exercises and asks her if she is experiencing any discomfort. Mrs. Johnson says that she is fine, but the therapist notices that her teeth are clenched and her voice is quivering. The therapist should:
- a. Consider the possibility that she is experiencing some pain.
 - b. Take her at her word and assume that she is not in pain.
 - c. Tell her that he questions her honesty.
 - d. Continue with the exercises until she tells him she is in pain.
11. As a health care provider, you must be sure your nonverbal behavior is consistent with your _____.
12. Although nonverbal communication can be very revealing, it can also be easily _____.
13. The same nonverbal act can have different meanings, depending on a person's cultural, religious, or family _____.
14. It is important to remember that nonverbal messages are clues to a person's feelings, not _____.

15. In order to consider a conversation to be an interview, all of the following conditions must exist EXCEPT:
- You plan the discussion in advance.
 - You have a specific objective or purpose for the conversation.
 - The meeting is of a professional nature.
 - You are keeping a written record of any information exchanged.
16. In a successful interview, the _____ should do most of the talking.
17. Mr. Stephens, a licensed vocational nurse, is interviewing one of his patients, Mr. Samuels, in order to obtain information about his medical history. During the course of the conversation, Mr. Samuels occasionally strays from the subject in order to boast about occasions from his past in which his behavior was what Mr. Stephens would consider to be childish and impolite. Mr. Stephens should:
- Tell him that he is not impressed and that he feels his behavior was improper.
 - Avoid making value judgments and let him continue to talk.
 - Document the discussion and tell him he would recommend counseling.
 - Tell him how he would have behaved in the same situation.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 2

On exercise in which you wrote your own answer, the solution provided below may not be the only acceptable solution. If your answer has the same meaning as the one provided, consider it correct.

1. Received (para 2-1b)
2. Expectations (para 2-2)
3. Symptoms (para 2-2)
4. Distracting (para 2-3b(1))
5. c (paras 2-4b, c, e)
6. Interrupt (para 2-4d)
7. How (para 2-5a)
8. a (paras 2-5a(4), (6), (8))
9. Nonverbal (para 2-5c)
10. a (para 2-6a)
11. Words (para 2-6b)
12. Misinterpreted (para 2-7a)
13. Background (para 2-7b)
14. Facts (para 2-7c)
15. d (paras 2-8a, b, c)
16. Interviewee (or patient) (para 2-9k)
17. b (para 2-9n)

END OF LESSON 2

LESSON ASSIGNMENT

LESSON 3

Patients' Rights.

TEXT ASSIGNMENT

Paragraphs 3-1 through 3-4.

LESSON OBJECTIVES

After completing this lesson, you should be able to:

- 3-1. Identify and discuss patients' rights.
- 3-2. Given a description of a situation, select the action a health care provider should take in dealing with a patient.

SUGGESTION

After completing the assignment, complete the exercises at the end of this lesson. These exercises will help you to achieve the lesson objectives.

LESSON 3

PATIENTS' RIGHTS

3-1. INTRODUCTION

a. Again, imagine yourself entering a hospital. Someone of authority replaces your clothes with standard blue pajamas. It seems to you that everyone working at the hospital has a greater knowledge than you of your own health. You are told what you may eat, when you may eat, when you may or may not sleep, when you may have visitors, and who they will be. In other words, your range of control over your life has been drastically reduced. In many aspects, you have been placed in a position of submission, under the authority of the health care providers.



b. As we mentioned previously, some people respond to these role changes with no apparent changes in their behavior or attitude. Others, however, unquestionably accept the authority of those in control. They overlook the fact that they have inherent legal and ethical rights as patients.

3-2. PATIENTS' RIGHTS

A list of patients' rights has been printed and widely accepted among medical facilities. As you contemplate the following list of some of those rights and how they relate to your particular health care role, remember that respect for the rights of the patient plays a large part in patient satisfaction and thereby the healing process. The following points can be applied to outpatient as well as inpatient settings.

a. The patient has the right to impartial access to treatment and accommodations regardless of race, creed, sex, national origin, religion, or sources of payment for his care.

b. The patient has the right to considerate and respectful care, with recognition of his personal dignity.

c. The patient has the right to every consideration of privacy concerning his own medical care program. Discussion of his case, consultations, examinations, and treatment must be conducted discreetly. Anyone not directly involved in the patient's care must have his permission to be present. The patient has the right to confidential treatment of all communications and records pertaining to his care.

d. The patient has the right to know the identity and professional status of individuals providing service to him. He also has the right to know of the existence of any professional relationships among individuals who are treating him, as well as the relationships to other health care institutions involved in his care.

e. The patient has the right to obtain information from the physician concerning diagnosis, treatment, and prognosis in terms that can be easily understood. When it is not medically advisable to give such information to the patient, the information should be made available to a legally authorized individual.

f. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. This includes such things as the specific procedure and/or treatment, the risks involved, alternatives for care or treatment, and the name of the person responsible for the procedures and/or treatment.

g. The patient has the right to know if the hospital plans to engage in or perform human experimentation affecting his care or treatment. He also has the right to refuse to participate in such projects.

h. The patient has the right to refuse treatment to the extent permitted by law.

i. When medically permissible, a patient may be transferred to another facility, but only after he has received an explanation as to the needs for and alternatives to such a transfer. Also, the institution to which the patient is to be sent must have first accepted the patient.

j. The patient has the right to reasonable continuity of care following hospitalization.

k. Regardless of the source of payment, the patient has the right to request and receive an itemized and detailed explanation of the hospital bill. (In a federal hospital, there would be a flat rate per day.)



I. The patient should be informed of the hospital rules and regulations, which apply to him as a patient.

NOTE: For a complete listing of patients' rights and responsibilities, see the Accreditation Manual for Hospitals (AMH), which is updated annually and can be found at most major medical facilities.

3-3. REGULATIONS AND LOCAL POLICY

a. There are a number of different ways that you can handle any situation, and there is not always one correct action to take. In some instances, you must just use your common sense. It is important, however, to become familiar with regulations and local policy. Policies may vary depending upon your location and/or your role. One example is the handling of patients' valuables. How can you safeguard a patient's valuables? What do you say if a patient wants to give you a few dollars to get him something from the hospital gift shop? Can you accept a small gift from a patient who wants to show his gratitude? Become familiar enough with the local regulations or policies to handle such situations before you are confronted with them.

b. The extent of information or advice you should provide to a patient depends upon your MOS. A physician should respond to questions dealing with diagnosis and treatment. However, you can always respond in some way to a health care receiver's request for information. If you are not authorized to answer his questions directly, you can find someone who can, direct the patient to someone who can, or get the information for him.

c. Again, be familiar with the local policy on dealing with information on treatment and diagnosis.

3-4. CLOSING

There are some rules that never vary. For example, a patient's medical history, diagnosis, treatment, and prescribed medications must always be considered confidential. Your relationships with patients should always be kept on a professional level. A patient should always be provided with as much privacy as possible. As a health care provider, your ethical responsibilities reach far beyond your legal requirements. You perform a service based on the trust that you will consistently perform in a manner that will benefit the patient. Living by this policy is an inherent and essential part of your job as a health care provider.

Continue with Exercises

EXERCISES, LESSON 3

INSTRUCTIONS: Answer the following exercises by marking the lettered response that best answers the question or best completes the statement or by writing your answer in the space provided.

After you have completed these exercises, turn to “Solutions to Exercises” at the end of the lesson and check your answers.

1. Patients have the right to considerate and respectful care, with recognition of their personal _____.
2. All patients have the right to know the identity and professional status of individuals providing _____ to them.
3. Patients have the right to information regarding diagnosis, treatment, and prognosis. In some cases, the information can be given to _____ individuals.
4. If a hospital plans to engage in human experimentation, any patients being affected have the right to be advised and to _____ involvement.

Check Your Answers on Next Page

SOLUTIONS TO EXERCISES, LESSON 3

On exercise in which you wrote your own answer, the solution provided below may not be the only acceptable solution. If your answer has the same meaning as the one provided, consider it correct.

1. Dignity. (para 3-2b)
2. Service. (para 3-2d)
3. Legally authorized. (para 3-2e)
4. Refuse. (para 3-2g)

END OF LESSON 3

COMMENT SHEET

SUBCOURSE MD0520 QUALITY OF CARE: PATIENT RELATIONS EDITION 100

Your comments about this subcourse are valuable and aid the writers in refining the subcourse and making it more usable. Please enter your comments in the space provided. ENCLOSE THIS FORM (OR A COPY) WITH YOUR ANSWER SHEET **ONLY** IF YOU HAVE COMMENTS ABOUT THIS SUBCOURSE..

FOR A WRITTEN REPLY, WRITE A SEPARATE LETTER AND INCLUDE SOCIAL SECURITY NUMBER, RETURN ADDRESS (and e-mail address, if possible), SUBCOURSE NUMBER AND EDITION, AND PARAGRAPH/EXERCISE/EXAMINATION ITEM NUMBER.

PLEASE COMPLETE THE FOLLOWING ITEMS:

(Use the reverse side of this sheet, if necessary.)

1. List any terms that were not defined properly.

2. List any errors.

paragraph error correction

3. List any suggestions you have to improve this subcourse.

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