

“Medical Communication”

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INTRODUCTION

We are living in what has been called the “Communication Age”. We are able to communicate information faster, more clearly and more widely than ever before in the history of civilization.

Today we are going to focus on medical communication and we’re going to have some interactive role playing designed to uncover typical strengths and weakness in communicating with patients about their problems. Think back for a minute on your own life experiences. What can you recall from your own interaction with your doctor or your dentist about the quality of the communication that was involved? Was it clear? Was it sympathetic? Were you left with the impression that you were told as much as you wanted to know? Were you left with the impression that your doctor was a good listener?

WHY IS THE QUALITY OF DOCTOR-PATIENT COMMUNICATION SO IMPORTANT?

In reviewing the subject of medical communication, I ran across six reasons why doctor-patient communication is worthy of our attention:

1. Patient Satisfaction. Communication skills are the single most important determinant of patient satisfaction with care (Cleary, Doering, Williams) and patient satisfaction with care is the primary determinant of patients’ decisions about which doctor, which hospitals, and which health care plans they will use (Newcomer, Aharoney). Remember that studies have shown that if a patient is satisfied with their interaction with a physician they will tell, on average, three other individuals about how pleased they were. On the other hand, if they are poorly satisfied with their encounter they will tell, on average, 19 other individuals about their unpleasant experience.
2. Studies have shown that good communication skills have a positive effect on the overall outcome of patient care and poor communication skills have a negative effect on the overall outcome of patient care.
3. Good communication skills have been shown to correlate with increased compliance with physician recommendations and adherence to proposed plans of therapy (Cegala).
4. Good communication skills can help doctors cope with an increased patient volume and a subsequent decrease in the amount of time available to spend per patient. On several occasions, I have heard patients praise a certain famous heart surgeon in Houston who is known to spend an average of 30 seconds with each patient while he makes his postoperative rounds. They described how he took a great deal of time to explain how the surgery had gone and that somehow he seemed to have the ability to make them feel that they were the most important patient of all those for whom he was providing care. This is a clear example of mastery in the art of physician-patient communication.

5. Good communication skill correlates with a decreased probability of medical/legal consequences. This past weekend, I listened to a lady in our bridge group describe her encounter with a physician in another city who saw her while she was on vacation. The physician diagnosed the pain and swelling in her right calf as an infection and treated with antibiotics. Several days later when she was no better, she returned and was seen by a second physician who diagnosed thrombophlebitis and urged her to be admitted to the hospital for treatment, which she did. About a week after that visit, she is much improved, and a few days ago the first physician whom she saw, the one who missed the diagnosis, called her to inquire how she was doing and to express her sincere sympathy for all that she had been through. The patient was extremely impressed by the phone call and the time the physician spent communicating with her. She expressed to the rest of us how much she wished that there were more physicians like this.

6. In some areas of the country, managed care organizations are beginning to survey patients, collect patient satisfaction data on individual physicians and make this information publicly available to patient and their employers. In many areas of the country, patient satisfaction scores are collected by health care organizations who then include this as key data in their decision regarding which physicians to include or exclude from specialist panels.

CAN COMMUNICATION SKILLS BE TAUGHT?

1. Definitely during medical school
2. It is a crucial part of residency training
3. It is more difficult for practicing physicians who lack these skills to be taught how to practice them. Remember that you are always learning something about how to communicate with patients as you observe other residents and faculty. You will observe some good role models and some good lessons in communication and you will observe some that are not so good.

SPECIAL MEDICAL COMMUNICATION SITUATIONS

1. End-of-life Communication. Conversations about the end of a patient's life are fraught with heavy emotional overtones. This is true whether it is a situation in which the physician is speaking directly with the patient or with the family. The situation is modified depending upon whether or not advance directives exist or whether you are trying to encourage some planning for a patient's impending demise.

Some thoughts about the content of end-of-life conversations:

- a. There should be a sincere and heart-felt expression of sympathy.
- b. Patients and family sometimes need to be reminded that the patient has had a good life.
- c. In almost all situations, the patient was realistic and knew that things would come to an end at some point.
- d. Usually, the patient was not happy with their pre-terminal condition and probably didn't want to live in that state.
- e. Emphasize that everyone involved did everything possible to keep the patient comfortable to the end.

f. Make an effort to understand and be sensitive to various cultural and religious perspectives about death that will apply in the case of this patient.

2. A second special conversation involves how to convey the diagnosis of cancer, or any major, serious illness that might lead to death or permanent disability. Some key points about this type of conversation follow:

- a. Before the conversation, be sure that the patient brings a family member to the meeting. This type of discussion should always be face-to-face and never over the phone or at a time when you are unprepared to deal with all of the demands of that situation.
- b. Allow enough time for all the patient's questions to be answered. These discussions are best held before a lunch break or at the end of the day if they are in your office. They may run much longer than you planned.
- c. Always present the same information and give the same thoughts about prognosis to both the patient and the patient's family.
- d. Present the whole truth, but it is all right to be optimistic.
- e. "I'm afraid that I have some bad news for you" is a reasonable way to begin the discussion. Remember that people will vary quite widely in their response to a diagnosis of cancer or another major illness. While you are talking about a health issue, they are thinking about (a) their loss of control over their body and fact that it has betrayed them, (b) their loss of identity as a healthy person and (c) their loss of relationships and roles in their life up to this point.
- f. Listen carefully to the response that patients have to the news that you are giving them and try to learn exactly what your words have meant to them.
- g. Listen carefully for their comments about their religious beliefs as these will frequently influence future discussions.
- h. Be empathetic.
- i. Don't take away the patient's hope.
- j. Understand that the patient may not comprehend much of what you have said to them, and they may not hear any of the conversation that follows after the word 'cancer'. This is an extremely loaded word that has the ability to jam all communications for some period of time after it enters the conversation.

LEARN TO LISTEN

Some doctors seem to believe that the art of medical communication consists of their training themselves to speak clearly and professionally so that they cannot possibly be misunderstood by their patients. While that is a good start, it is equally important to learn how to listen. Some comments about listening:

- a. Every patient comes to you with an agenda. Sometimes the agenda is short and simple, sometimes it is lengthy and convoluted. To get to the heart of patient problems and to establish the rapport that is necessary for successful treatment, we often have to spend a considerable amount of time pursuing the items on the patient's agenda. Listen to what they are saying and listen to what they are not saying as you take a careful history.

- b. Remember that patients seldom return to doctors who don't take the time to listen to what they have to say.
- c. Remember that you don't really know if the patient is hearing what you have to say, unless you listen to the questions they are asking and the comments they are making.
- d. Videotaped interviews show that doctors interrupt their patients and redirect the communication to areas that they want to learn about after an average of 19 seconds of patient dialogue. Patients often have more than one agenda item, and it is better to allow them to express their entire agenda before you divert the information flow in another direction.

BARRIERS TO OPTIMAL MEDICAL COMMUNICATION

There are many significant barriers to what we might define as ideal medical communication. Some of these barriers exist within patients and their families and the most important of these are:

- a. Patients and their families frequently tend to steer conversations away from difficult or emotionally-laden topics.
- b. Shyness, confusion, and fear of death or disability.
- c. Sometimes patients and their families are simply unable to accept bad news.
- d. Patients and their families have a tendency to over-estimate the probability of a cure in difficult situations. Television programs focusing on doctor-heros tend to emphasize the happier outcomes.
- e. Information obtained from the Internet and the news media may frequently confuse patients and cause them to have difficulty hearing your message.

Other barriers to optimal medical communication may reside within some of us as physicians for various reasons such as:

- a. Physicians frequently fear causing pain with the bad news they have to convey.
- b. Some physicians lack good communication skills.
- c. Some doctors view death as an enemy to be defeated. When death or disability cannot be prevented they take it personally and feel that they have failed as a physician.
- d. Some physicians tend to anticipate a disagreeable response from patients or their family, and in order to avoid this they present a misleading picture of the patient's condition and prognosis for full recovery.
- e. Some physicians fear the medical/legal consequences of the strong negative reactions that some patients have to bad news. Having to convey the probability of a negative outcome causes them to feel powerless and vulnerable and results in communication that is less than candid.

INTERACTIVE MEDICAL COMMUNICATION VIGNETTES:

Vignette #1. You are referred a 37-year-old attorney who awoke 9 days ago with a complete loss of hearing in his right ear. He saw his PCP the next morning and the doctor prescribed a 10-day course of antibiotics for an ear infection. There has been no improvement in his hearing loss. You find a normal appearing TM and your tuning fork tests suggest a severe unilateral sensorineural hearing loss. You now enter the exam room and begin to explain the situation to him and answer his questions.

Vignette #2. You are referred a 21-year-old attractive college student who awoke 3 weeks ago with a complete left facial paralysis. She describes mild pain behind her left ear and on physical examination you find a normal appearing left tympanic membrane and conjunctivitis of the left eye. She has been reassured by her primary care physician that "most of these facial paralyses tend to recover spontaneously". You order a nerve excitability test (4.5 milliampere difference between the left ear and the right ear, ENOG shows 95% degeneration and EMG shows only a very few fibrillation potentials). You now enter the exam room and begin to explain the situation and answer her questions.

Vignette #3. You are asked to see an 18-month-old male who was taken to see the doctor because of his apparent lack of awareness of environmental sounds and his lack of speech development. You examine the child and find him to be in excellent health otherwise, and after testing the impression of the audiologist is that of bilateral profound sensorineural hearing loss. You now enter the room and begin to explain the situation and answer the questions of the parents.

Vignette #4. A prominent 45-year-old banker in your community comes to see you because of progressively increasing hoarseness. He smokes two packages of cigarettes per day and has two or three cocktails every evening, and he just wants to be sure that he doesn't have anything to worry about. On fiberoptic examination of his larynx you note that he has an irregular exophytic lesion involving the entire left true vocal fold and that there is no vocal fold motion on the left. You remove the fiberoptic scope and place it on your examination console and then you turn to the patient and begin to explain the situation and answer his questions.

Vignette #5. Yesterday you were on call for the Emergency Room at your hospital and took care of a 19-year-old female who had been involved in automobile accident at 1:30 a.m. You determined that she had a severe LeFort III fracture with massive facial swelling. You were able to reduce and plate the fracture and it is now Monday afternoon. The patient was minimally responsive yesterday afternoon, but upon awakening this morning, your friendly ophthalmologist consultant has shared with you that the patient appears to have no useful vision in either eye. You have also just learned that the tox screen performed in the E.R. is positive for marijuana and an alcohol blood level of .21. You now enter the patient's hospital room and begin to explain the situation to the patient and her parents.

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