Making Yourself Understood
Communication:

By Philip G. Winkelaar, MD, BSc, FCFP, DGM

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The headline in *The Ottawa Citizen* (Nov. 19, 2001) recently shouted: "Doctors Rude, Arrogant."[1] A similar report appeared in the *Canadian Medical Association Journal*.[2] Both referred to discussions at the Royal College of Physicians and Surgeons of Canada meeting, at which Dr. Nuala Kenny was reported to have commented on the use of derogatory language by physicians. In the same articles, Dr. Dennis Kendel, Registrar of the College of Physicians and Surgeons of Saskatchewan, was quoted as saying rudeness was a factor in a large portion of the complaints received at his college. As if to confirm this, a recent issue of the *Members Dialogue of the College Physicians and Surgeons of Ontario* was devoted largely to topics of communication.[3] The Canadian Medical Protective Association, and other bodies, often identify poor communication as a key factor in the majority of patient complaints to a hospital or a licensing body. Some patients even take legal action by bringing these matters to court.[4-6]

Doctors need to communicate throughout the day every day. They may talk to patients, nurses, other doctors, office staff or to patients' family members — the list is nearly endless. To the regret of some doctors, however, they may find talking to someone is not necessarily communicating with that person. We speak (or write) to each of these people to communicate an idea, instructions, advice or even empathy. Whether this is actually communicated depends on a host of factors, but primarily on whether the message is actually received and understood. The information we are trying to impart must be tailored to each individ-

ual's needs, and the form of communication must be related to the person's capacity to understand.

Good Communication, Good Care

Communication with patients is the foundation on which good health care is built. It is important for every doctor to understand a few things about his/her patients. For example, why have they come to you? It may be a referral from a trusted doctor or a previous patient who sang your praises, or because their previous doctor discharged them. Each of these scenarios might change your approach to the patient.

What language do the patients speak? If you speak the same language, do you speak it well enough for them to understand? Do you understand them? What is the their level of education? What past experiences have they had? These factors are important, both when choosing the words you use and the descriptions you give. Saying to patients, "It's no more dangerous than an appendectomy," will mean one thing to a person who doesn't know what an appendectomy is, but something entirely different to someone whose uncle had an abscess and died of sepsis. Some people are offended if they feel you are "talking down" to them, while others will be embarrassed to admit they don't understand.

Dr. Winkelaar is medical officer in the physician consulting services of the Canadian Medical Protective Association, Ottawa, Ontario.

Doctors who only talk "to" patients will miss important information the patient is capable of giving. The doctor must take the time to listen. A frequently quoted article states the doctor interrupts most patients less than 18 seconds after the interview begins.[7] Unfortunately, many of those interruptions may have been intended as encouragement for the patient to continue, but frequently, such interruptions stop the patient's train of thought.

Taking the time to listen demonstrates respect for the patient and helps to develop the vital rapport that makes patient care both successful and rewarding. A patient will trust his/her doctor if he/she feels respected, can talk to his/her doctor and ask questions and have them answered clearly. A trusting patient is more likely to be compliant with the doctor's advice, including recommendations for follow-up, making the whole encounter mutually satisfying. If there is doubt about the patient's understanding, or if the instructions are complicated, it is often useful to write them down. It is always a good idea to ask a question or two before the patient leaves so you can ensure you have succeeded in making yourself understood.

Communication is often impeded by high emotion on the part of the patient or doctor. At these times, it is even more important for communication to be clear and effective.[8]

Administrative communication is often overlooked. This communication includes such mundane matters as your office hours, your coverage arrangements (*i.e.,* what should the patient do in the middle of the night or on a long weekend?), how you deal with laboratory reports and referrals, *etc.* Armed with this information, patients can take some responsibility for their care, knowing it will meet with your approval. Patients also will be expected to fulfill the obligations you have indicated in your administrative

policies. Failure to communicate such policies has been a significant factor in some complaints and lawsuits.[6,9]

The Office Team

A doctor's office is also a communications vehicle. Patients form an opinion of the doctor, based on various factors (*i.e.,* the person who answers the telephone, the appearance of the office and the way they are greeted as they arrive). Doctors are legally responsible for their office staff, and must take reasonable steps to ensure staff behaviour is appropriate.

Every year, complaints to licensing bodies relate to the way patients feel the doctor's staff has treated them. Colleges and boards have cautioned physicians about the management of their offices. It is important to have clear guidelines for staff. Management experts recommend written policies and advise regular review of the policies and the staff's understanding of them. This is another opportunity for two-way communication — staff members often have important insights they can share, if the doctor is receptive.

The Hospital Team

Within the hospital, the team includes nurses, paramedical staff, consultants and physicians who cover during your absence. Clear communication with these people usually demands clear and careful charting. Nurses' notes may contain valuable information. In these days of reduced staffing, it is not uncommon for physicians to find there is no nurse available when they make rounds. In some facilities, communication can be achieved through a "communication book." If not, the nurses' notes may need to be perused. Failure to do this has led to adverse consequences for patients. These patients subsequently brought legal action against doctors, who, in turn, could not be defended successfully.[10] Whether the significant information is in a communication book, the nurses' notes, or received verbally, the physician should somehow demonstrate it has been received and understood. Orders written in response to such communications are indirect evidence of this, but if no orders are written, a note should be made in the record to indicate you have taken this information into consideration.

Communication with members of the health-care team must be clear and appropriate. Hospital staff have complained about doctors when verbal orders were misconstrued or doctors expressed anger or other inappropriate emotions.[11]

Summary

Making Yourself Understood: The Purpose of Communication

- Doctors who only talk "to" patients will miss important information the patient is capable of giving. The doctor must take the time to listen.
- Communication is often impeded by high emotion on the part of the patient or doctor. At these times, it is even more important for communication to be clear and effective.
- A major cause of problems within hospitals is the failure of doctors to communicate their expectations to each other.
- Communication with colleagues should be adequately documented.

Talking with Colleagues

A major cause of problems within hospitals is the failure of doctors to communicate their expectations to each other.[5] Are you simply

Communication with members of the health-care team must be clear and appropriate. The use of well-defined technical terms can lead to an improved understanding between physicians.

requesting an opinion and advice? Do you want the consultant to write down orders, or perhaps to assume care of your patient? At what point will you expect to resume responsibility for the patient's care? When responsibility for a patient has been transferred, it is important to inform all your colleagues, as well as other members of the caregiving team. Many hospitals make it a policy to identify on the patient's chart the "most responsible physician" (the doctor who has overall responsibility for the patient's care) and to update this chart whenever a transfer of responsibility occurs.[12]

Communication with colleagues should be adequately documented. While it is not uncommon for a doctor to hold a "corridor consultation" or request a consultation in passing, it is important that vital information about the patient be given to the consultant. Furthermore, any actions taken on the basis of a consultation should be documented so your colleagues and consultants can understand the problems, see the actions you have taken and monitor the outcomes of those actions before giving further opinions or taking responsibility in the case.

Consultants also can contribute greatly to the optimum treatment of patients by clearly stating their recommendations for investigation, treatment and follow-up. It is important for the consultant to clarify the responsibility for further action and the indications for re-referral.

In a hospital, colleagues also include laboratory and radiology consultants. The requests for their services must include relevant and useful clinical information so they will understand your patients' needs and your expectations. Their reports, like those of other consultants, should answer the question being asked by the requesting doctor.

Jargon, Abbreviations and Penmanship

The use of well-defined technical terms can lead to an improved understanding between physicians. However, jargon is often not based on mutually agreed-upon definitions. Even simple matters, such as the numbering of fingers is inconsistent, while abbreviations (*e.g.,* NAD,

SOB) are similarly open to misinterpretation. Poor handwriting makes this all the worse.

Talking to Families

When communicating with families, it is important to respect the patient's right to confidentiality. No discussion should occur without the patient's authorization, or, if the patient is not competent, authorization should be given by a legally appropriate substitute. Once again, the issues of education, language, comprehension and prior experience need to be considered. Cultural values and role perceptions in a family may not be immediately apparent, but a physician should be aware of the possibility of their existence and be prepared to adapt the interview to those factors. During a consultation, it is often useful to have the family in the room with the patient, so the information given to both is the same and differences in interpretation can be identified and corrected.

Summary

While talking is a natural function, communication is an art that demands constant attention. Careful choice of words and descriptions is vital. Listening to the other party reveals the patient's or other listener's concerns and questions. Understanding should be assessed and confirmed. Finally, good documentation will make it possible to confirm just what was said, in the event some part of the discussion is misconstrued or forgotten, despite all efforts to communicate clearly. CME

References

1. Doctors Rude, Arrogant. *The Ottawa Citizen*, November 19, 2001.
2. Kondro W: Are physicians too rude? Can Med Assoc J 2001; 165(10):1376.
3. Members' Dialogue, College of Physicians and Surgeons of Ontario, September/October 2001.
4. Reduce Problem Patient Liability. Ob-Gyn Malpractice Prevention, December 1999; 6(12):890.
5. Messenger OJ: Communication Problems Between Doctors. CMPA Information Letter, Spring 1987; 2(2):1.
6. Gluck M: Communication in Obstetric Practice, Canadian Medical Protective Association (CMPA) Information Letter, Spring 1988; 3(2):1.
7. Beckman HB, Frankel RM: The effect of physician behavior on the collection of data. Annals of Internal Medicine 1984; 101:692-6.
8. Fraser P: CMPA Information Letter, Winter 1998; 13(3):2.
9. Gluck M: Communication in Obstetric Practice, CMPA Information Letter, Spring 1988; 3(2):1.
10. Winkelaar P: Communication in Obstetric Practice, CMPA Information Letter, January 2000; 15(1):1.
11. Winkelaar P: Communication in Obstetric Practice, CMPA Information Letter, Spring 1999; 14(1):1.
12. Gambhir IB: Communication in Obstetric Practice, CMPA Information Letter, May 2000; 15(2):1.

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