Communicating Effectively for Interventional Nephrologists

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Introduction: Why a Chapter on Communication in an Interventional Text?

The finest work in medicine will go unnoticed by patients, referring physicians, colleagues, payers, and other large organizations if the information regarding the procedure, the outcome, future plans, and implications for care are not effectively communicated. This chapter will discuss the most current thinking regarding individual and organizational communication to assist the physician in creating and sustaining a robust practice.

Improved communications between physicians and their patients have been clearly shown to lead to both improved patient and physician satisfaction but also to better outcomes [1–4]. An extensive review of this literature is beyond the scope of this chapter. What is becoming clearer, however, is that not only is direct communication with the patient important, but good communication with other colleagues and the entire system of care clearly improves patient safety and outcomes [5, 6]. In addition, good treatment or mistreatment of the medical staff will be reflected in the physician's ability to deliver care [7]. Therefore, developing effective communication becomes an important skill to deliver effective care.

One of the cornerstones of the success of an interventional practice has been communication with referral sources. Communication between the interventional physician and the referral source can take multiple forms: verbal, written, and imaging. The use of as many avenues as possible to transmit information can improve the results and satisfaction of the patients, dialysis clinics, nephrologists, surgeons, and primary care practitioners. Each of the recipients will have unique pieces of information that they need to achieve a satisfactory interaction.

Satisfaction of a referral source with the results of your work has been shown to be proportional to the communications received from the consultant [8]. The information stated as most valued by referral sources was direct feedback, both written and verbal, with acknowledgment of the patient's history, suggestions or need for future care, scheduled follow-up if needed, and plans for comanaging care in the future. Of all of these, the inclusion of the plans for comanaging the patient's care in the future was directly proportional to the referring physician's overall satisfaction [9–11].

For interventional nephrology, one can substitute the dialysis facility, the general nephrologists, and access surgeon for the above entities.

What Is Good Communication and How Does It Impact Care?

The essence of good communication is the effective transfer of information. Communication is effective when these transfers occur in such a way as to build relationship, trust, confidence, and synchronicity. Much has been written on the art and science of good communication.

Many organizations will cite the issue of communication as a central one in their quest for effectiveness and efficiency [12, 13]. It is a common theme. In spite of this, it is possible for good communication can happen without great effort. There are often small but important changes that can make a big difference.

What elements are the markers of excellence in communication? Although information can be transferred without attention to relationship, the result is not as effective. The reason is simple: Communication must occur between human parties. It is of vital importance that a level of trust is established and maintained to ensure the best results from all parties. People must feel they can trust one another to do their best work, to be reliable and dependable.

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Communication can inspire confidence in the abilities of the individuals involved. It brings a more profound level of commitment from people when they have confidence in those with whom they work [14, 15].

Any complex system will function most efficiently when its members function with a high level of synchronicity. If parties are functioning in isolation, not informing one another of their efforts or updating needed information, then a murkiness and confusion develop. None of the participants has all the needed tools to be truly successful. Muddled and ad hoc processes result, leaving many people feeling entirely incapable of addressing simple, let alone complex, problems.

It is important for a physician to realize that any health care is delivered in a complex system that starts with a patient physician interaction and then involves multiple caregivers and systems. Physicians work in concert with many. Although it may seem not to be the case, there is a high level of interdependence that exists in the world of the interventional physician. At the core is the partnership with the patient. Without getting all necessary information from the patient, the physician cannot do his/her best work as all issues are not taken into consideration. In turn, the physician must transfer information to the patient in such a way as to encourage the patient to follow the plan of care with confidence. In other words, the patient has a large part in the maintenance of their own health, and if they do not have a sufficient understanding of their role, they are not as likely to do their part [4].

An interventional needs referrals to maintain their practice. These are ongoing relationships that require good communication. However, in the course of busy days and under much pressure, a strained dynamic may develop. Staff and doctors may find it hard to get information they need from each other, and tempers may flare as both parties face the pressure of long days and high levels of stress.

Good communication skills help decrease the stress of these situations. Finally, most doctors work within some sort of institution and are dependent upon that institution for patients, contracts, funding, and support. Likewise, the institution depends on the doctor to complete their part in a cost-effective and quality manner to keep the business viable. So it is clear that doctors function not in isolation but as part of a complex web of human activity. This interdependence requires constant continued effective communication and relationship building for all parties to function with excellence.

Strategies for Excellent Communication

It is important to note that delivering information is not the same as communicating. Communication is not a one-way delivery but a multitrack exchange. Information must travel back and forth between parties (two or more) to be considered communication. To begin with, different people have very different learning styles. This has been analyzed in many ways. For our purpose, we will look at the following element: Some learn best visually, some by auditory means, and some kinetically [16]. Therefore it is very important to deliver information in at least two of these three ways, at all times.

This means that the delivery of a pamphlet alone is not a communication. The individual receiving the pamphlet must then read it and understand it and be able to interact with the material. If they do not, the pamphlet may as well be blank. So handing someone a pamphlet must not be construed as a communication. However, checking with someone about the material contained therein and answering questions as needed, or discussing the material, constitute successful communication. In this example, two modes of communication have been employed: both visual and auditory. The visual is the pamphlet which is a reading material, and the auditory exchange is the conversation. In the same way, sending a memo, writing a report, or leaving a message is not a complete communication cycle.

The information must be confirmed and shared in some other way via vocal or pictorial means. Several strategies may help physicians improve their communication skills. We will look at three: active listening, use of questions, and the feedback model. Although there are numerous methods to improve communication, these three are excellent core skill-building strategies that will empower physicians to become great communicators without setting up complex new systems or changing organizational structures.

These are skills that can be learned, practiced, and employed right away and do not take up excessive time or energies in already busy, stressful work days.

Active Listening

Listening is a key skill in the pursuit of good communication. For many, "listening" means waiting for the other person to stop speaking so we can make our point. For some who think quickly and grasp concepts easily, hearing someone out at length may be tiresome. For those who are under tremendous time constraints and have crucial information to impart, both of these reactions can hinder the ability to communicate effectively. In order to communicate well, one must cultivate real empathy. Empathy is an understanding of the situation from the other person's point of view. Without this shared understanding, there is no real or effective communication that will happen [17, 18].

The solution is a technique called active listening. It comes from psychologist Carl Rogers, PhD, who also pioneered the ideas of congruence and unconditional positive

regard [19]. Congruence means being aware of our own reactions and emotions, so we can convey those in a clear and honest way. The misconception is that when we are feeling irritated, for example, we can plaster on a smile and no one will know. That is rarely the case. Usually those around us are aware on some level that something is not right, though they may only be able to guess at the reason. It is simply a better, cleaner approach to become very aware of our reactions and deal with them directly. For instance, that same irritation, once recognized, can be examined to understand its cause. It may come from a time crunch, a poor diagnosis, or a bad breakfast.

Being aware helps us deal with the issue and not project it upon those around us or try to hide and come across as "false." Unconditional positive regard is an attitude taken by a practitioner in which one holds the client or patient in a positive regard. This means understanding them as human beings doing their best with what they have, as worthy and acceptable, despite any possible perceived shortcomings.

This level of regard engenders tremendous trust as it allows the person to feel accepted on a deep level. Both these practices support the technique of active listening. The technique is done by first finding a baseline level of regard for the person speaking, then actually listening to what they say, without working on our response or preparing our thoughts. When the person is done speaking, the listener checks for understanding. This is important. The listener reflects or returns the information back as they have understood it, checking to see if they have captured the meaning.

"I hear you say you need more lead time to get those reports complete." The speaker is thereby given the opportunity to clarify as needed. This clarity results in a much greater level of shared understanding. This is really a very simple technique and can become a valuable tool. It can be used in any situation in which the exchange of information is very important, be that between physician and patient, physician and staff, or physician and referring doctor. It is especially useful when there has been some misunderstanding or shortcoming in communication in the past. This may seem more time-consuming, but the clarity of information, lack of misunderstandings, and absence of a need for repeated communications will actually result in a more efficient exchange (Fig. 4.1).

Use of Questions

Much conflict arises in any workplace as a result of "jumping to conclusions." Of course it is the most natural thing to draw conclusions from what we see around us and the assumptions we make about what we see. The problem is when we

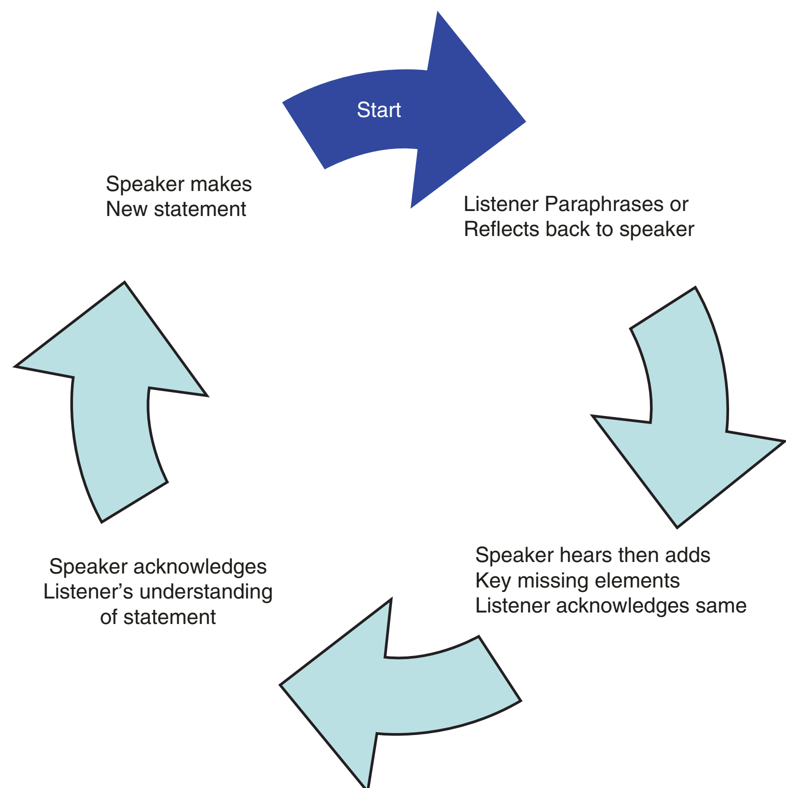

Fig. 4.1 Active listening cycle

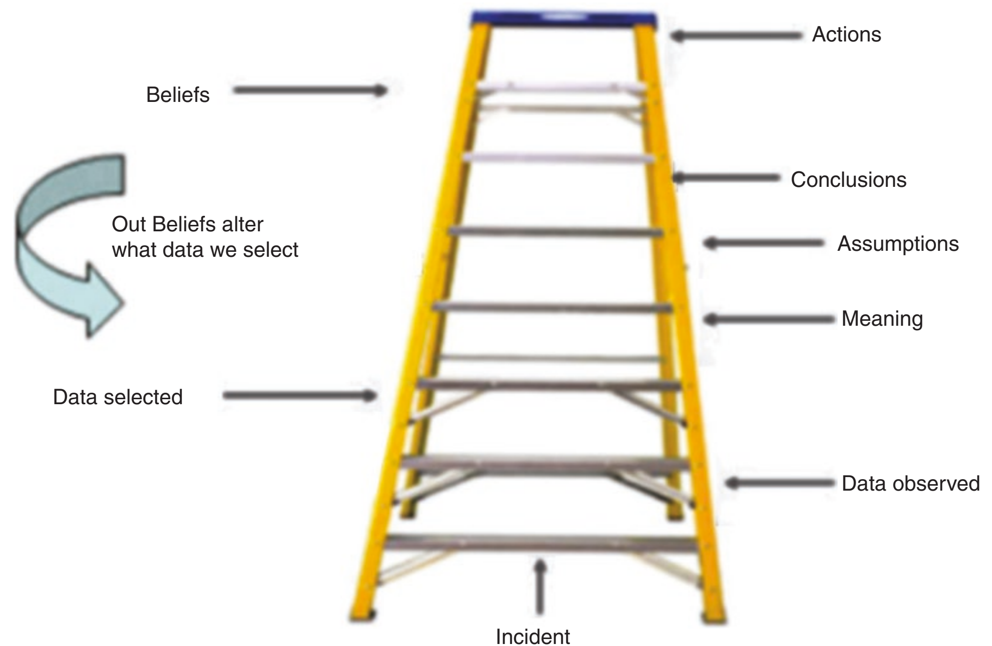

Fig. 4.2 Ladder of interference

confuse our assumptions with fact. However, facts cannot be determined without checking those assumptions.

This is illustrated by the "ladder of inference" (LI) [20] (Fig. 4.2). The ladder shows how we take observations and begin to climb the ladder forming beliefs that inform our actions. However, the data we draw from our observations, the meaning we give that data, the assumptions, and conclusions we draw are all subjective. Without taking time to check things through, to question our own impressions, we may end up building belief systems that are structurally flawed.

The solution is in exploring perceptions through use of questions. The first place to intervene on the ladder is at the lowest level, checking with others about the information available and its possible meaning, before we make assumptions and draw conclusions. We all tend to work, unconsciously, in a network of assumptions and preconceptions. It is a very effective technique to begin asking question on a regular basis. Recognizing where we have assumed information is the hardest part. It might be helpful to start with a few generic questions to use regularly, such as "What have I missed?" or "What more would you like to hear about?"

Physicians use questions as a tool routinely to collect data. The types of questions normally used are closed-ended questions that allow only specific responses. "On a scale of 1–10, what is your pain?" or "Did you eat breakfast today?"

To explore our assumptions, we must use open-ended questions, allowing the responder to choose what information to share. "Can you help me understand the choice you made there?" "I see a strong reaction from you; can you tell me what is going on?" "Is there something more you need from me to make this work better?" Each type of question has its place. One of the things to learn is that "yes" or "no" questions will limit the communication rather than expand it. Those closed-ended questions make it far too easy to evade real communication for both parties. While closed-ended questions can be useful, they rarely enhance a relationship. Ask questions that inspire some thought, and require some explanation. Those thoughtful answers may actually produce needed information. Most importantly, they make the person feel appreciated and relationship building occurs. There is great power in recognizing an individual by offering them the opportunity to reflect and be heard.

Feedback Model

Some situations in the workplace can be contentious. Conflict is not easy to handle for many people. Some avoid it by closing their office doors, some by barking or snapping after letting things build up, and some by exhausting themselves by pretending to be "fine" at all times. The problem with allowing conflict to submerge in these unhealthy ways is that true solutions to problems are never addressed.

Conflict is most often the result not of individual relational issues but of more complex sets of circumstances or misunderstandings. Something small can sometimes grow out of proportion, or the original cause may even get lost over time with only the conflict and avoidance remaining. The cost is tremendous exertion of energy that could better be used in more productive ways.

Unresolved conflict can be very taxing indeed to the individuals and systems involved. One solution to deal with conflict is to handle it right away and not let it fester. This

involves a simple way of phrasing issues that makes it possible for both parties to view the situation in a new light without blame or hostility. We require tools to handle conflict, however, and many are never taught any of those tools. One tool is the feedback model.

The essence of this approach is that we choose to address the conflict by talking about specific behavior and our reactions to that behavior, rather than speak in generalities. The first principle of this model is to understand that when we are upset or irritated by something, it is our own issue. The irritation is our own. The upset is because of our perception, history, viewpoint, and values.

The other person may or may not have meant the insult or offense. Remember the ladder of inference. What may seem like a fact, "She obviously disdains my work," may come from a series of assumptions based on misunderstood data. What makes this conclusion seem real? "I saw the look on her face."

As above, the use of questions can be very helpful. "What was that look on your face about?" The answer may be, "I have indigestion." Or even something surprising like, "I was impressed with your work and suddenly felt inadequate. Did I make a face?" If the answer in fact is "I wasn't impressed with your work," then the good news is that issue is out in the open and can be discussed. Use questions such as "Can you tell me what your judgment is based on?" Maybe there is more hidden misunderstanding that now has an opportunity to come to light. If the objective is one of data collection, the mining effort can be very helpful. As painful as certain answers may be, carrying around worry and distress as we imagine things, and make up stories about reasons, is usually far worse.

The feedback model is a way of reflecting our experience to bring deeper understanding. The first step is to figure out what is the behavior in the other person that is upsetting. The second step is to identify that behavior to the person and let them know the effect it has on you and the conclusions you draw. The reason this works is because it takes both parties into account in the behavior and reaction cycle. The conflict is not just due to the initiator of a certain behavior but also the reactions and conclusions of the other person.

This way of giving feedback is collaborative, because it takes ownership of reactions, rather than blaming the other for our reactions [21] (Table 4.1). Compare this to the usual approach, "You're such a jerk! You are always nasty to me and treat me like dirt." Sadly, this more common approach undermines resolution by using vague and broad, even insulting descriptions that cannot be addressed in any concrete way. What is a "jerk?" The accused must respond to the insults in a defensive manner, rather than gain understanding about the behavior which is something that can be addressed.

Table 4.1 Three steps for productive feedback

	What is said	What is the process
1	"When you snap at me in front of patients…"	This is the behavior
2	"It causes me embarrassment..."	This is the effect
3	"And I assume you have no respect for me."	This is the conclusion

The above technique does not guarantee a change in behavior, but it will successfully let the person know the effect they have with their chosen behavior. At that point both parties must "own" their individual part. The answer may be, "I do respect you… I just get frustrated, but it is not personal." Now both people know where they stand. If this is not comfortable, then it would be important to seek additional support within your company or an outside consultant if needed.

Communicating with Referral Sources

The principles discussed above will assist you in communicating with your referral sources. Each of the referral sources will want a different part of the information you have as a result of your care. In this section the specifics needed from each party are discussed. However, it is still important that the information be effectively communicated using the techniques described above.

The Patient

The patient may want an understanding of the importance of the dialysis access in their lives, the risks of the procedure, the probability that they will need future procedures, and the expected outcome for them in the future.

They may also want a sense of confidence and safety with the procedure that does not necessarily come from verbal communication alone but nonverbal as well. While general information describing the procedure and the known risks may be communicated in handouts or pamphlets, nothing can take the place of the availability and willingness of the physician to directly speak with the patient. Pictures printed or drawn or copies of the actual images will clarify an enormous amount of technical information, and using techniques like active listening and asking questions will help build that confidence and safety (Table 4.2).

Nephrologists

Nephrologists need to know different information. Most nephrologists are "on the road" a lot and might not be able to immediately take the time to receive oral communication. Some physicians may even prefer written to oral communi-

Table 4.2 Communicating to referral sources

Entity	Mode	Required data	Future needs	Making it better
Patient	1. Oral	1. Risks/benefits	1. When?	Pre-tx pamphlets
	2. Pictures	2. Why?	2. What?	Post-tx images
	3. Written	3. Results	3. How?	
Nephrologists	1. Written	1. Success?	1. How long?	Know which doctors like phone calls
	2. Oral	2. Dialysis now	2. Tx options	Send images with reports
	3. Pictures		3. Next site?	
			4. Referral?	
Surgeons	1. Oral	1. Anatomy	1. Tx options	Send images
	2. Pictures	2. Tx response	2. How long	Specifics in report and images
	3. Written	3. Alter surgery	3. New sites	
Dialysis units	1. Pictures	1. Use today?	1. Is more tx needed? When?	Images of access –especially "stick zone"
	2. Written	3. New orders	2. Needed f/u?	
	3. Oral	3. New orders	3. Orders?	
Payers	Written	Justify tx	Practice trends?	Know requirements

Evidence for the table is based on research from studies of radiological literature [22–25]
Tx treatment, *f/u* follow up

cation, and it is easy to ask them when the opportunity presents itself. This may be very individual, but written information will reliably be available via email, fax, or ideally the same electronic medical records as long as Health Insurance Portability and Accountability Act (HIPAA) standards are met. As to the type of information needed, it is important to estimate the degree of the procedural success and the ability of the patient to dialyze immediately. Images, if you are able to provide them, will help the physician to understand your communications better. Use questions to check for mutual understanding, and use more than one type of communication to insure complete clarity.

Surgeons

Surgeons are very individual in the specifics they want. The communication with your surgeon may need to be oral until you understand what they individually need, and then it can be predominately written. This would be primarily in the form of your dictation. Complete imaging of the venous and sometimes arterial anatomy will assist in surgical planning.

There is no substitute for actual images and a detailed description of the anatomy in surgical care. Clearly, several modes of information delivery are required. Be aware of your ladder of inference, and check facts and understanding with surgeons as you establish a working relationship.

Dialysis Units

Dialysis units are very specific and immediate in their needs. Can they dialyze now? Do they need to be rescheduled? Dialysis staff often does not have time to come to the phone. Unless it is urgent with regard to the care of the patient today, it may not be really useful. If verbal communications are needed, of course they are readily appreciated. However, for routine information, a written report and ideally a picture of where the problems are and where to "stick" will be appreciated.

Remember to conclude by checking for understanding. Repeat back information to confirm you have it right. Ask an open-ended question like "is there anything else you need to know?" The ability to successful communicate with the dialysis staff may be most important in terms of your ability to grow your practice.

Payers

For now the primary source of communication with payers is your dictation. It should include the diagnosis, name of procedure, and indication for the procedure. It should also document the degree of abnormality that made the intervention necessary and the immediate response to treatment. The Kidney Disease Outcomes Quality Initiative (K/DOQI) standards are the most pertinent [26].

For instance, the minimum degree of stenosis that will qualify for angioplasty is 50%, and a successful angioplasty is judged by the response of the lesion to be decreased to less than 30% residual stenosis. The American Society of Diagnostic and Interventional Nephrology (ASDIN) coding manual may be very useful in this regard [27]. Legal issues may arise from performing procedures.

While no pre-procedure plans to communicate with attorneys in advance should exist, it is important that elements of your written documentation satisfy the standards of care in your community and in this field of medicine.

Documentation of your consent and explanation of the procedure are needed. Some documentation of pre-sedation

assessment will be needed for cases where sedation is used. Documenting the "time-out" or a procedural "pause" in the procedure room is now standard of care at most facilities. The procedural dictation itself should be as detailed as needed for payers and for the above physician referral sources. Again all your communications, oral, written, or imaging, will be viewed by different people in different contexts. It is important to be aware of this as you perform each procedure and discuss the outcome with the interested parties.

Taking these last two areas of communication into account may seem tedious, but the fact remains that the physician must interact, again, with the larger web of human and organizational structures that make up the whole. They do not function in isolation and cannot simply do their "job" without understanding their dependence upon the larger structure and the dependence that structure has upon them.

Organizational Communication

Corporations can be seen as living entities. They have their own needs, such as maintaining a reputation and increasing revenue year to year. At the same time, the corporation is made up of networks of individuals with their own needs.

They wish to be respected, appreciated, and understood. This is why the skill of communicating with individuals and relationship building with those individuals with whom you have contact within the corporation is so important.

They make up the pieces of the whole. Just like people, organizations adopt cultures and personalities. Organizational communication is far more difficult to understand and more difficult to change than individual interactions. Whether it is the government, professional societies, hospitals, health maintenance organizations, large dialysis groups, or the newly developing accountable care organizations, physicians will have to interact with large organizations in some way. It is important to realize that some of the strategies for communication are the same for this sort of communication and some are different [28–31].

Companies like to align themselves with others who share their view of the "world." Companies will not participate in enterprises that have too large an investment without a guaranteed return or enterprises they do not believe will make money in the long run or might be negative for public relations.

Understanding this will influence what you say and how you say it when discussing your practice with potential partners and contractors. If you do not understand the wants and needs of the organization you are working with, then questioning techniques as described above are helpful to understand what the issues are. "What is the company looking for? What is your role in the company? Is there specific information you need to assist you in making this decision?" Empathy or the ability to understand the information you have from the view of the organization is extremely advantageous.

Do not forget that each conversation you have with an employee of an organization is with a person. So active listening will assist in building trust and better understanding between people. The specifics of the information exchanged will be different, but the people and techniques are the same.

Your ability to present the data needed in an effective manner may become important in the survival of your practice. As the evolution of health care continues, you may need to present data ranging from the ability of your staff to communicate to your complication rate and the cost efficiency of your practice. All this data is highly valued by many organizations. It will not be enough to say "I practice good medicine." Information will be needed regarding the delivery of quality service, cost efficiency, and rate of complications compared to the rest of those in your field.

Thus it may be important in the future to participate in national databases which collect patient safety information. In the corporate world, such by data can be obtained using continuous quality improvement techniques [32]. Many of the lessons from manufacturing have been applied with some success to health care [33, 34]. Quality improvement (QI) in the manufacturing business is a large field that is beyond the scope of this chapter, but the techniques can be useful in maintaining and improving your practice. Even when there is a large amount of data available, it is still essential to communicate the information well to your corporate colleagues in order to be successful. The techniques described for improving individual communication can apply to corporations.

Conclusion

Much depends on continued individual, institutional, and corporate communications to survive in a changing healthcare landscape. While practicing medicine can be done without good communications, practicing excellent medicine cannot.

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