Communication in Healthcare

4

Faiz Motiwala, Hanif Motiwala,
and Sanchia S. Goonewardene

Communication is at the heart of legal complaints. Often the first hurdle and pitfall for many doctors is how they communicate with their patients; when done well it allows the establishment of good rapport. When done poorly it can lead to series of outcomes ranging from a slight confusion or misunderstanding, to a barrage of complaints [1]. It is very much a clinical skill and the application of it can determine good clinical practice and patient satisfaction. The GMC stress its importance [2] and many medical schools have increasingly introduced it as a clinical skill to learn and cultivate from the beginning of medical school. The importance of this communication extends to communicating with other staff members such as ward clerks, therapists, nurses, HCAs as well as between doctors on the same clinical team or between different specialties.

4.1 Discussions with Patients

The most common themes in complaints suggest that patients are more likely to resort to medico-legal consultation when there is a breakdown in communication. These may arise from difficulty in contacting the clinician, if the patient is met with a defensive, arrogant or condescending attitude, or being provided an inadequate

F. Motiwala
Queen Elizabeth Hospital, Woolwich, UK
e-mail: faiz.motiwala@nhs.net

H. Motiwala
Department of Urology, Southend University Hospital, Southend, UK

S. S. Goonewardene (✉)
Department of Urology, The Princess Alexandra Hospital, Harlow, UK

F. Motiwala et al. (eds.), *When Things Go Wrong In Urology*,
https://doi.org/10.1007/978-3-031-13658-0_4

explanation from the clinician [3]. The importance of communication cannot be emphasised more. In these circumstances the clinician should place themselves in the patient's position and attempt to understand their situation. By embracing the situation, it enables the clinician to clear any misunderstandings, work to resolve the situation and prevent recurrences in the future.

Within urology many of the patients' conditions are a sensitive topic and procedures have known complications associated with them that can continue to impact quality of life. It is imperative that the patient has a full understanding of their condition and a realistic expectation is provided.

Speak in simple terms, avoid use of technical jargon—peeing instead of micturition, bleeding instead of haemorrhage. Vivid descriptions and colourful language have their place but may not be the most sensible choice in a discussion with patients (or in clinical records for that matter). Care should be taken when describing the course of events in an operation and particularly in the use of technical jargon. While it may prove one's intellect and increase a patient's respect for you, some will not understand what you are saying rendering the conversation relatively pointless. More importantly one should note whether the patient is absorbing the information being presented to them. Are they deaf? Are they just nodding along? Is English their first language or is an interpreter necessary?

One should also attribute due caution to describing events to patients. The patient may interpret or latch onto terms such as, 'a lot of pulling' or 'sudden haemorrhage'. To the surgeon these can be of little concern but to the lay person may suggest something terrible has happened to them; the term 'haemorrhage' in and of itself suggests a more serious connotation than the term 'bleeding' in the colloquial language. Careless remarks easily roll off the tongue and have been highlighted in reports, such as when a bereaved daughter was told "death is rarely an ideal situation for anyone" and that "truth be told your mother probably said her goodbyes long before the final moments" [3]. Needless to say, the daughter did not respond well to the remark.

Unless you have a good long-standing relationship with a patient or the atmosphere is appropriate, you should generally avoid laughing or cracking jokes during the consultation. Laughing can be viewed as inappropriate or offensive to some patients. An amusing joke may lose its hilarity when it is being repeated back to you in the court by the claimant's lawyer. That is not to say you should remain stone-faced and unflinching during the consultation. Consultations are not just about seeking information; they form and establish rapport for a presumably long relationship that they might trust your judgement. It is not beyond a surgeon to be friendly and sociable!

Another facet to communication is the body language depicted to the patient. Communication is a duality; it does not consist only of speaking. Take the time to listen attentively to your patients, show empathy and an expression of understanding of their concerns. Simple mannerisms include turning your body toward the patient and giving them due attention; at that moment in time they should feel that they are the most important person to you. Watching the clock, paying attention to

your bleep or being distracted by minor things are not the recommend ways to instil confidence and trustworthiness in your patient.

Be clear in the words used to describe something. Often this stems from discomfort in telling a patient out of the fear of upsetting them. For example, terms such as 'growth' have been used to describe cancer which can be interpreted in a multitude of ways. Using unclear terms can cause confusion or cause a patient to lose confidence or trust in their clinician. The worst consequence of this that it can lull people into a false sense of security. This can result in their failure to keep important appointments or chase results if there is a breakdown in administrative follow-up which can become a brewing complaint or worse. While one's compassion may drive them to use euphemisms or avoid clear terms, these should only be reserved for when there is genuine concern that using clear terms would be detrimental to their health or care. Otherwise be clear. If you mean 'cancer', say 'cancer'.

In these circumstances, one may not be simply suggesting the possible diagnosis, but rather telling them a diagnosis. "Breaking bad news" is a common requirement for any doctor. It is a complex and sensitive task, requiring a compassionate and tactful approach. The right approach can make coping with a difficult situation easier for a patient and their family. In 2000, Baile and colleagues published in The Oncologist a six-step model for disclosing this information—the widely popularised SPIKES model (Fig. 4.1) [4].

SPIKES

- **Set up**
  - Plan the discussion in advance. Choose an appropriate quiet location with enough seating.
  - Suggest to the patient to be accompanied by a significant other.
  - Put your bleep on silent or give it to someone else to prevent any interruptions.
  - Establish rapport. Make a connection with the patient through means such as eye contact or holding their arm (if appropriate).
- **Perception**
  - Employ the principle "before you tell, ask." Allow the patient to express their emotions and ask questions.
  - Open ended question to establish what the patient knows and help guide the delivery of your information/message.
- **Invitation**
  - Check the patient or relatives are actually willing to listen to what you say or if they are avoiding listening to you
  - If they are avoiding details, offer to speak in the future or discuss with family / friends if appropriate

Fig. 4.1 A model of SPIKES—adapted from Baile and colleagues' publication

- **Knowledge**
  - A warning the patient of bad news can lessen the shock of its disclosure
  - Provide information at an appropriate pace
  - Use appropriate language – avoid technical jargon
  - Provide information in small chunks and check their understanding periodically.
  - Reassure the patient of ongoing support (especially with a poor prognosis!)
- **Empathy**
  - Allow a brief period to give them the time to absorb the information and express their emotions
  - Observe and validate the patient's emotions
- **Strategy and summary**
  - Make sure they understand by summarising the pertinent points and encourage them to express their concerns.
  - Provide some material for them to absorb when they are ready
  - Suggest the option to note down any information to properly address these questions at a next meeting.

Fig. 4.1 (continued)

The approach can be applied for any situation or person. You may be telling a patient that their renal cancer has recurred despite their nephrectomy or updating the patient's relatives that their loved one is fighting for their life in ICU. Discussion with family members or friends can seem a daunting task but is a common occurrence and essential in some circumstances. Friends or relatives can provide a secondary history or act as a second pair of eyes or ears. Their helpfulness should not be underestimated when explaining conditions to patients or seeking consent for procedures.

4.2 The Angry Patient

An angry patient or relative is an unavoidable truth in clinical practice. There are always reasons behind a patient's anger such as bad news, fear, or misunderstandings. They may have been kept waiting for their appointment, investigation, or treatment, they may have suffered a complication, or perhaps it is simply a culmination of all the problems in their life.

Whatever the reason may be, it is important to stay cool and calm. Never respond to an angry patient with anger, despite any temptation to raise your voice or argue with the patient. Place yourself in their shoes and try to understand what is driving their anger. Apologise for their situation. Empathise. Be patient. Be supportive. This is one of the situations where you want to use your body language to tell them they have your full attention. Legitimising their anger, for example with a phrase such as 'I understand you are upset...' shows you are paying attention to them and allows

them the opportunity to explain themselves [5]. Using the term 'I understand how you feel…' may do more harm, causing them to challenge you despite your best intentions. Empathising with the patient's feelings shows them that you do care and wish for their well-being. This will work in the majority of cases with the patient viewing you as a friend as opposed to an adversary, allowing you to work towards a solution.

If despite your best attempts they continue to be angry or if physical aggression is imminent, tell them calmly and clearly that you cannot continue any further discussion with them in these circumstances. Inform them you are going to leave the room and give them the chance to cool off. Offer them a second opinion or to see your colleague at a later date, if you feel this to be the source of the problem.

It is vital to protect yourself and others in these circumstances and should call security if required. On some occasions the police may need to be involved and you would have to justify disclosing confidential information to them.

Make sure to record details of the consultation, noting what was said. Direct quotations are helpful. Record explanations provided and the apologies made. This act of writing can also help you to reflect on the situation. Speaking to angry patients can be quite taxing and you may need a break or relax before seeing the next patient to ensure you are calm and attentive. If you have the time, discussing with a trusted colleague can be helpful.

4.3 Managing Patient Expectations

From the moment a patient chooses to seek healthcare, expectations are formed in their mind consciously or subconsciously. A simple expectation may be simply for them to find out what their problem is or how to treat it. A more complex expectation may arise from the desire of a particular investigation to exclude a particular problem before a basic assessment is even performed. For each encounter, patients will have differing expectations. These expectations have shifted alongside advances in medical care, including their desire to complain should they receive care they perceive to be inadequate.

The rising number of complaints are not shown to be associated with a reduction in the quality of care provided; this is evident in claims being filed relating to non-clinical reasons such as poor communication [6, 7]. The surgeon may perceive the care they provided was good, viewing success purely from clinical outcomes. In contrast, the patient may place emphasis on the overall experience and other factors such if they felt cared for. So, for what reasons can we view the same experience differently?

4.3.1 Information

Patients can often attend appointments with a perception of their diagnosis and the treatment required. Universal access to the internet has meant patients can find information (often inaccurate) from numerous websites. They may also have been informed certain things from either the GP or A&E physicians which is

contradictory to the specialist opinion. This may result in expectations of investigations or treatment that may not be offered or simply inappropriate for their symptoms. Conversely patients may have a lack of information and not expect prolonged waiting times for their appointment, or that their symptom of visible haematuria may in fact be a brewing bladder cancer.

4.3.2 Time Pressures

Perceptions of time can greatly vary. Clinicians can see 10–20 patients in a general day or clinic, whereas for that one patient that patient there is only that one appointment. The emphasis placed on an interaction can be influenced by the allotted clinic times and other commitments, such as an unwell patient or a patient requiring emergency surgery. A short or rushed encounter can make it difficult to check with a patient if they can fully understand the condition, diagnosis, reasons for investigations and treatment options. When relevant, offer leaflets and the opportunity for the patient to relay information back to you and ask questions. Seek the support of other colleagues or seniors when you are struggling in these situations, especially with the concern of quality of care being compromised. If it is a situation with a general shortage of staff, the service manager and departmental lead should be made aware.

Within the outpatient clinic setting, the view of BAUS is that enormous clinics are no longer appropriate [8]. There needs to be adequate time to provide patients with relevant information to allow them make decisions, to provide counselling, and to document the discussion surrounding the consent process. The generally suggested numbers for an outpatient clinic with new and follow-up patients is approximately 12 (6 new and 6 follow-ups, assuming 15 min for follow-up patients and 20 min for new patients). This length of time should allow for dictation of letters. Of course, these numbers will vary between each surgeon and what you are comfortable with. Patients with cancer may require even longer consultations e.g., 30 min as these may involve breaking bad news. Specialist complex clinics typically require longer clinic times with new patients requiring between 30–45 min. Other clinics such as the one stop clinic include many more investigations and a full review of the patient and as such should have more dedicated time e.g., 40–50 min. Unfortunately, these recommendations are not always followed, with some people seeing a larger number of patients and not being able to give enough time to each patient. If there are persisting issues with patient numbers in the clinic setting, a trainee should escalate to their consultant and supervisor. As a consultant, this should be escalated to the service manager, and subsequently the clinical director if required. Patient care should never be compromised.

4.3.3 Patient Anxiety or Depression

Patients may be anxious or depressed when being reviewed, compounding any of the above factors and increasing the possibility of misunderstandings arising. Although there are no clear solutions to this problem (especially when might not

even be aware that the patient is anxious or depressed), you can still adopt and apply principles such as those in the SPIKES model. Being empathetic and understanding of their plight will establish a sense of rapport and meet the expectations from some patients. Remain patient. Be clear and use simple language, avoiding technical jargon. Invite them to have someone close to them involved in the discussions. Allow them to ask questions without speaking over them. On the more serious topics you may want to check they have absorbed the information by asking them to repeat it back to you. Information from clinic appointments can be supplemented with leaflets or posters in waiting rooms. If the patient is someone who explores the recesses of the internet about information on their condition, refer them to reputable websites such as the BAUS website (baus.org.uk), 'patient.co.uk' or the NHS website with the specific details of their condition.

4.4 Communicating with Staff

There should be clear active communication between the team members. In fact, a significant proportion of medical errors can be avoided through good communication and collaboration between team members. Ensure there is a clear system of communication between seniors and juniors, especially for the junior to contact the senior in case of emergency. They should not fear contacting the on-call consultant for advice on clinical or administrative problems. The team should also be mindful of the atmosphere and any discussions in front of patients, especially during procedures under local anaesthetic or cystoscopies. It can be friendly and pleasant (which is preferable!) but must remain sufficiently professional. If any of the staff laugh and joke during the procedures or in conversation about the patient, these may be misconstrued by the patient as laughter at their expense. Some of these procedures can seem minor or inconsequential to us due to the sheer number we perform but can be an uncomfortable and worrying time for the patient. It remains our responsibility to conduct ourselves with due manner and preserve the patient's dignity.

References

1. Koul PA. Effective communication, the heart of the art of medicine. Lung India. 2017;34(1):95–6.
2. General Medical Council. The duties of a doctor registered with the General Medical Council. March 2013. www.gmc-uk.org/guidance/good_medical_practice/duties_of_a_doctor.asp. Accessed March 2020.
3. UK Parliamentary and Health Service Ombudsman—Listening and Learning report. November 2012. https://www.theioi.org/ioi-news/current-news/release-of-report-listening-and-learning. Accessed May 2020.
4. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist. 2000;5(4):302–11.
5. Dingley C, Daugherty K, Derieg MK, et al. Improving patient safety through provider communication strategy enhancements. In: Henriksen K, Battles JB, Keyes MA, et al., editors. Advances in patient safety: new directions and alternative approaches (Vol. 3: Performance and tools). Rockville, MD: Agency for Healthcare Research and Quality (US); 2008.

6. O'Daniel M, Rosenstein AH. Professional communication and team collaboration (Chapter 33). In: Hughes RG, editor. Patient safety and quality: an evidence-based handbook for nurses. Rockville, MD: Agency for Healthcare Research and Quality (US); 2008.
7. Ha JF, Longnecker N. Doctor-patient communication: a review. Ochsner J. 2010;10(1):38–43.
8. A guide to job planning for consultant urologists. BAUS. 2016. https://www.baus.org.uk/_user-files/pages/files/Publications/2016%20Job%20Planning%20for%20Consultants.pdf. Accessed May 2020.