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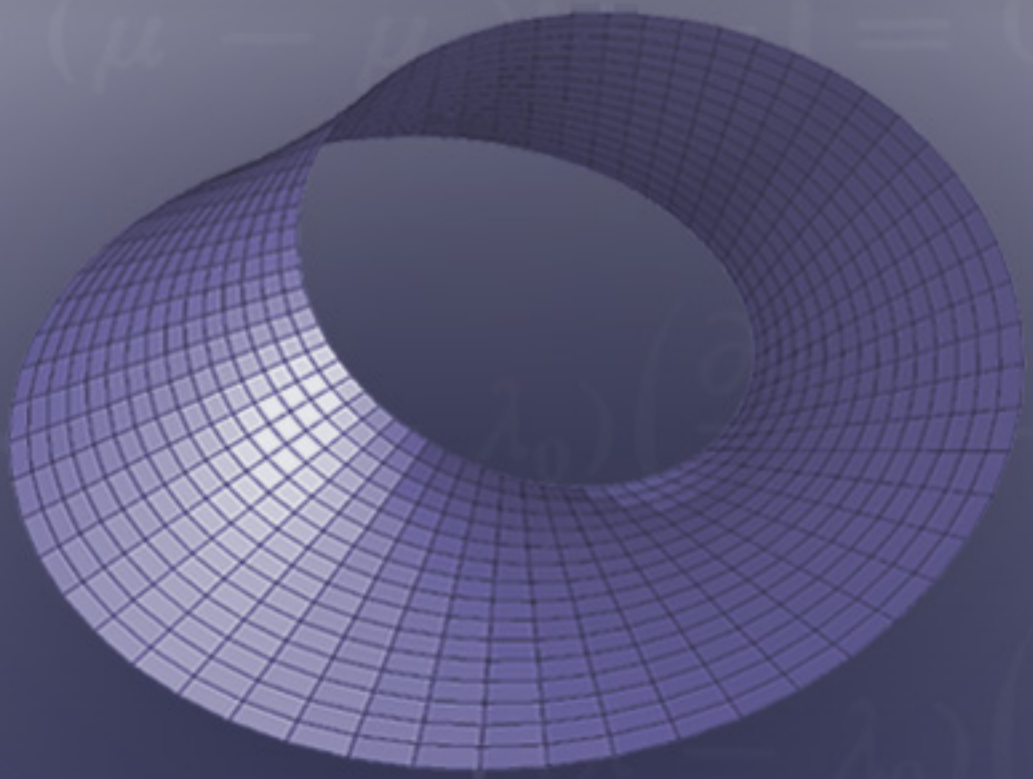
Communication in the Practice of Medicine



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ΕΛΛΗΝΙΚΗ ΧΕΙΡΟΥΡΓΙΚΗ ΕΤΑΙΡΕΙΑ ΕΤΟΣ ΙΔΡΥΣΕΩΣ 1928
ΒΡΑΒΕΙΟ ΑΚΑΔΗΜΙΑΣ ΑΘΗΝΩΝ 1978

ΕΛΛΗΝΙΚΗ ΧΕΙΡΟΥΡΓΙΚΗ

HELLENIC JOURNAL OF SURGERY

HELLENIC SURGICAL SOCIETY FOUNDED 1928
ATHENS ACADEMY AWARD 1978

SpringerWienNewYork

Hellenic Journal of Surgery 2010; 82: 2

Communication in the Practice of Medicine

Editorial

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Received 29/06/2010 Accepted 23/08/2010

For the most part, the majority of us live quite well, uneasily trying to laugh in the face of death and concurring with Woody Allen's aphorism: "I am not afraid of death, I just don't want to be there when it happens."

Deep down, we are clinging onto two basic beliefs: the first is linked to the fact that we think of ourselves as unique and special. The other is our belief in a superlative saviour. These are universal beliefs which, at some level of consciousness, we all embrace.

Being special is related to our belief that we are invulnerable, inviolable –beyond the natural laws of human biology and destiny. But there comes a time in everyone's life when we have to face a crisis, such as a serious illness, a career setback or a breakup. And it is then that we mumble the phrase: "I never thought it could happen to me".

While the belief in our specialness provides us with a sense of inner security, the other major mechanism of denying death –our belief in an ultimate saviour– allows us to feel that an outside power watches over us and protects us at all times. Although we may feel shaken up, fall ill, or even reach the dire brink of life, we remain convinced there is an omnipotent being hidden somewhere, who will bring us back to normal.

Very often, this omnipotent being comes in the form of a doctor, and more precisely, a surgeon.
And who is this being? Nowadays, it is the person who, to a great extent, has replaced the clergyman who used to stand by the sick body and the suffering soul, who used to be at your side when faced with the existential anguish and inescapable, hard facts of life.

The facts of life that may have influenced today's surgeons at the age of 3, 8, 12 or 18 in such a way that made them want to control uncertainty, to prevail over death, to cure pains that they have themselves felt, to become invulnerable and omnipotent, a shaman, in an effort to seek perfection through science and the art of surgery.

In our times, due to the prolongation of life expectancy and the decrease in deadly contagious diseases, medicine is indeed advancing beyond the paradigm of acute disease to that of chronic disease. Effectively, this requires a new kind of treatment, since the disease is often a long-term component of one's life, and therefore the role and the relation of the doctor to both illness and patient have entered a new phase. In recent years, in particular, new technologies and medical infrastructures combined with the general feeling of the public have lead to a remarkable growth in the surgical sector and brought the relationship between surgeons and their patients to a new level of maturity.

In hospitals, found almost everywhere nowadays, patients undergo extremely complex surgical cures. Modern surgery offers doctors the chance to bring their patients back to health, safely and with less pain. Surgeons are no longer the last resort for one's salvation; surgical operations can also play a curative role.

The nature of surgical therapy, which is often imperative and occasionally life-threatening, has a decisive role in the way the relationship between the surgeons and their patients is formed. It requires a particular degree of trust on the patient's side and, accordingly, a code of conduct on the part of the surgeon that is not only ethically correct but also adequate as far as its communicative aspects are concerned.

And why do we refer to the communicative aspects of this relation? Because communication lies at the heart of the two-way relationship between doctor and patient and deals with psychological features and incidents that have developed in the interim, while narration, whether lengthy or consisting of only a few words, is the medium through which the experience is transformed and internalised.

This is an experience that, for the patient's part, reflects the private and unique nature of his/her dis-

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ease, whereas for the doctor it represents the fulfilment that comes with action. Through the evaluation and therapy of a patient's condition, the power and control of the clinical encounter is gradually transferred from the patient to the surgeon. Initially, it is the patient who controls the relationship by choosing to visit the physician and enter into treatment. Ideally, the surgeon and patient discuss therapeutic options and decide together on how to proceed. Eventually, it is the surgeon and his/her operating team who assume total control during the operation. This transfer of power and control differs substantially from the power dynamics between patients and practitioners in most other fields of medicine. Medical patients, in general, retain a substantial degree of control over their care. A patient with hypertension, for instance, may listen to their internist explain the risks and benefits of controlling their blood pressure with a variety of medications, but ultimately it is they who choose to take antihypertensive medication or modify their diet. The complete, unavoidable, albeit temporary transfer of autonomy to the physician inherent in surgical therapy makes it imperative that surgeons fully appreciate moral obligations implicit in the surgeon-patient relationship.

When a patient presents with a health problem to the surgeon, either emergently or electively, he/she seeks the skills and advice of an expert who possesses the knowledge and skills inaccessible to the non-surgeon. The patient thus trusts the surgeon with their life, well-being, and private information. As we all know, the surgeon will attend and act on the patient's body in a way that no one else can, not even the patient himself. It is not only patients who trust the surgeon with their bodies and their health; spouses, parents and others who care for the patient also trust the physician with their loved one.

Once trust has been established, no matter how fragile or forced, patients hold several expectations. First, they have expectations of goodwill and beneficence that their physician will act in the patient's interest, and not in their own or anybody else's interest. Included in the expectations of beneficence are also the expectations concerning advocacy - that surgeons will advocate with third parties such as insurers or nurses for the good of the patient. Second, they hold expectations of competence, and even a good outcome; they expect that their trust in the surgeon will be justified because the surgeon is knowledgeable and skillful. Finally, they expect honesty and openness.

Trust between the patient and the surgeon may differ from other physician-patient relationships for several reasons. In many physician-patient relationships, trust develops through a prolonged, continuous process of care in which patient and physician together reach a diagnosis and implement a care plan. This care plan can and should be continually revisited as the patient's circumstances change. Patients thus retain control of the treatment process. In addition, the relationship has time to develop and mature.

Unfortunately, patients often present with surgical problems needing urgent or emergent therapy, where there is very little time, if any, to develop a strong bond. This urgent and intense need to trust is further compounded by the high risks involved in surgical therapy, including death and permanent disability.

Good communication with patients has always been essential in medical practice. It is the "cornerstone" of the physician-patient relationship. Open, honest communication builds trust and promotes healing. It favourably impacts patient behaviour, health outcomes, patient satisfaction, and often reduces the incidence of malpractice actions. For physicians, good communication with patients can also increase professional satisfaction, enhance community image, and provide a competitive economic advantage for the medical practice on one level. On another level, it is acknowledged that emotional involvement is a sign of growth, since the ability of a human being to form relationships and ties on a personal and professional level protects them from phenomena such as burnout and depression. These phenomena are not always easily discerned because they are often disguised under social dramatizations.

Increasing demands on surgeons in today's healthcare environment often leave them with less time to provide care to a greater number of patients. While time constraints can make it difficult to communicate as effectively as one would like, the quality of time spent with the patient remains very important. For this reason, effective patient-focused communication skills are essential. They can be applied quickly and effectively within the normal patient encounter.

When time is of the essence, it is the quality and not necessarily the quantity of physician-patient communication that is vital. To the patient, quality is often measured by how well the physician listens and acknowledges patient concerns. It is measured by how thoroughly the physician explains the diagnosis and treatment options, and how well the physician involves the patient in decisions concerning his or her care. These factors play an important part

in the way patients perceive, recall, and evaluate their visits with the physician. Good communication between a surgeon and his/her patient can act as a very useful mechanism for risk management.

While all this seems easy to discuss and analyse, surgeons indisputably have a difficult and complex balance to maintain; Anatole Broyard, an editor and author who died of prostate cancer, wrote as follows: "Physicians have been taught in medical school that they must keep the patient at a distance because there isn't time ... or because if the doctor becomes involved in the patient's predicament, the emotional burden will be too great. As I've suggested, it doesn't take much time to make good contact, but beyond that, the emotional burden of avoiding the patient may be much harder on the doctor than he imagines. ... A doctor's job would be so much more interesting and satisfying if he simply let himself plunge into the patient, if he could lose his own fear of falling".

But from the surgeon who should have solid scientific knowledge, make decisions and take action within a limited time-frame, and deal with the unpredictable postoperative course of the patients' health, the sleepless nights and the irregular sleep when he/she is on duty, who must handle the constant everyday contact with people under severe stress, the intensely competitive environment and carry the fear of a bad outcome, that can in just one moment stain and erase decades of tireless efforts – from that person, are we asking too much?

No, we are not asking too much. On the contrary, we are saying that the surgeon can achieve even more from all the wonderful things they do, if they practice their communicational skills more.

Yet, as a discipline, surgery has paid little attention to teaching communication skills -possibly because four common myths feed physician cynicism about communication. These myths about communication are:

- Physicians are born with (or without) communication skills - they can't be taught.
- Most physicians are pretty good communicators already.
- Good communication requires having a lot of time.
- Regardless of how good or bad the communication is, the outcome for the patient will be the same anyway.

All of these beliefs are false.

What Patients Want to Know vs What They Are Told

Empirical research indicates that, in many clinical situations, communication could be improved. Doctors commonly overlook the full range of patients' concerns, even when patients give relatively high ratings of global satisfaction with the encounter. The gaps between what patients want to know and how physicians perform only become evident when patients are asked whether physicians discussed the implications of bad news. Among the patients in one study, 57% wanted to discuss life expectancy but only 27% of physicians actually did this. Only 14% of the patients felt that diagnostic disclosure was the most important aspect of a bad news discussion; many patients felt that other factors were more important, such as prognosis (52% of patients) and treatment (18%). Most of the patients in the study group (63%) wanted to discuss the effects of cancer on other aspects of life, yet only 35% reported having had these discussions.

Physicians overlook the Patient's Perspective

Doctors also often fail to accurately detect patient distress during a clinical encounter. In one qualitative study, the researcher was present during the encounter and later interviewed the patient and doctor separately; only one of the five doctors was reliably accurate in assessing patient distress and anxiety related to the encounter. These findings contrasted with the specific physicians' self-assessment of their own performance. They rated their own performance favourably and were highly satisfied with it. These data suggest that self-perception of communication skills may be inaccurate. Do we want to do something about this? Do we consider it important?

Part of the explanation for this finding emerges from other studies showing that physicians tend to focus on the technical aspects of treatment without describing possible outcomes and without eliciting patients' values and goals.

Clinical Consequences of Poor Communication

Suboptimal communication can have negative clinical consequences for both physician and patient. Poor communication skills can compromise a physician's ability to assess and manage pain and other physical symptoms, as well as psychological issues, including anxiety, depression, and adjustment to illness. In addition, poor communication places physicians at greater risk for malpractice, as patient reports of poor communication, especially in the USA, correlate highly with increased rates of malpractice claims. And, finally, clinicians with little exposure to communication-skills training are at higher risk of burnout.

Patients recognize the centrality of communica-

tion in the doctor-patient relationship, although they have little control over the communication skills of their physicians. Patients with undisclosed concerns suffer from increased levels of anxiety and distress. In a study of patients with breast cancer who were surveyed 6 months after surgery, adjustment to illness correlated positively with better physician interpersonal skills during the cancer diagnostic interview; the only other significant patient factors identified in this study were a history of psychiatric problems and life stressors that predated the cancer, neither of which can impact as much as the oncologist's own communication.

Interestingly, this study indicates that the physician's caring attitude proved more important than the information given during the clinical encounter.

Guiding Difficult Decisions and Supporting Hope

Communication also influences patient decision-making. Patients who have an inaccurate understanding of their illness may make decisions based on unrealistic assumptions. Finally, good communication skills can foster a patient's hope. Talking about hope is a touchstone for oncologists and patients, and hope was the most important emotional need identified by a focus group of patients with cancer. How hope is framed can be a useful tool to add to a surgeon's repertoire of communication skills.

What is the meaning of all this? What can give more meaning to the significant work a surgeon does is the attentive and empathetic listening to a patient's narration, to his/her words and symptoms, a narration that can serve as a cause for reconstruction: on the patient's part, a reconstruction both physical and psychological effected by the doctor's hands, while on the doctor's part, a reconstruction on a psychological level through his/her supportive presence, that contains a hidden reconciliation between omnipotence on the one hand and uncertainty and imperfection on the other.

And we all collectively face these issues. We cannot talk about them in terms of "them" and "their" problems. Instead, we should be talking of "us" and "our" problems, because our lives, our existence will always be closely connected with death, as love is connected with loss, freedom with fear and growing-up with separation.

We are all in this together.

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This editorial is based on an invited speech delivered at the 3nd Hellenic Conference and International forum of the Hellenic College of Surgions (Athens, 17-19 April, 2008)

Η Επικοινωνία της Ιατρικής Πράξης

Editorial

M. Μεϊμάρης

Περίληψη

Η φύση της χειρουργικής θεραπείας, συχνά επιτακτική και ενδεχομένως κάποιες φορές επικίνδυνη για τη ζωή, διαμορφώνει με τρόπο αποφασιστικό τη σχέση μεταξύ του χειρουργού και του ασθενούς του και απαιτεί έναν ιδιαίτερο βαθμό εμπιστοσύνης από την πλευρά του ασθενούς και, αντιστοίχως, όχι μόνο δεοντολογικά ορθής αλλά και επικοινωνιακά ολοκληρωμένης συμπεριφοράς εκ μέρους του χειρουργού. Η επικοινωνιακή νότα αφορά την αμφίδρομη σχέση γιατρού-ασθενούς και διαπραγματεύεται ψυχικά κομμάτια και γεγονότα αναπτυγμένα σε έναν ενδιάμεσο χώρο, που μέσα από την αφήγηση είτε με δυο λέξεις είτε με εκτενείς προτάσεις θα καταστήσει μεταλλακτικά εσωτερικεύσιμη την εμπειρία.

Η καλή επικοινωνία με τους ασθενείς είναι εξαιρετικά σημαντική στην ιατρική πρακτική. Αποτελεί τον ακρογωνιαίο λίθο της σχέσης γιατρού-ασθενούς. Η ανοικτή, ειλικρινής επικοινωνία οικοδομεί εμπιστοσύνη και προάγει τη θεραπευτική διαδικασία. Έχει θετική επίδραση στην συμπεριφορά του ασθενούς, στην πορεία της υγείας του, την αίσθηση ικανοποίησης του ασθενούς και συχνά μειώνει τις περιπτώσεις λαθών στην εξάσκηση του επαγγέλματος. Για τους γιατρούς, η καλή επικοινωνία με τους ασθενείς μπορεί επίσης να αυξήσει την ικανοποίηση που λαμβάνουν από το επάγγελμά τους, να βελτιώσει την εικόνα τους στο πλαίσιο της κοινότητας, και να τους προσφέρει ανταγωνιστικό οικονομικό πλεονέκτημα στην άσκηση του επαγγέλματός τους σε πρώτη ανάγνωση. Σε δεύτερη ανάγνωση, η συναισθηματική εμπλοκή αποτελεί παράγοντα ωρίμανσης, καθώς η ικανότητα του ανθρώπου να έχει σχέσεις και να δημιουργεί δεσμούς όπως αυτοί αντιστοιχούν στον προσωπικό και επαγγελματικό τομέα προστατεύει από σύγχρονα φαινόμενα, όπως το "burn out" και η κατάθλιψη. Φαινόμενα τα οποία συχνά δεν είναι εύκολα διακριτά γιατί σαγηνευτικά μεταμφιέζονται πίσω από κοινωνικές εκδραματίσεις.

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