6 Communication and Patient Safety

Mark Gorney, MD

SUMMARY

Faulty communication is among the most common underlying causes of medical error and frequently erodes the doctor–patient relationship. Communication should be understood in the broadest sense, including nonverbal, oral, and written. This chapter reviews the most common mechanisms responsible for communication failures and recommends specific routines to minimize or avoid them altogether.

Key Words: Poor listening habits; nonverbal; speech tempo; body language; repetition.

INTRODUCTION

Patient anger underlies many malpractice claims and frequently results from ineffective communication. The breakdown is usually between doctor and patient but may also involve miscommunication between physicians and nurses or between physicians and family members.

Mastering the art of listening and increasing one's awareness of both verbal and nonverbal expression are important aspects of contemporary medical practice. Patients are increasingly assuming responsi-

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bility for their health care and often come to the doctor armed with information they have obtained from health-related websites on the Internet. They expect the doctor to listen to their complaints. They often have sufficient knowledge about their condition to ask intelligent questions, which may make the physician defensive, evasive, or hostile. This may be perceived by the patient as arrogance, leading to feelings of frustration, disappointment, and anger.

LISTENING

Hearing and listening are dissimilar processes. Listening is an active, cognitive process that involves interpreting what is heard and deciding on a response.

Most of our waking day is spent in some form of communication, and much of that time is listening. In the office and at the bedside, the amount of time a physician spends listening is even greater. According to Edward Kelsay *(1)*, of the four basic communication skills (listening, speaking, reading, and writing), listening is the least apt to be formally taught.

Dr. Ralph G. Nichols of the University of Minnesota, a nationally recognized authority and researcher on the nuances of listening, believes that effective listening requires conscious effort *(2)*. Busy physicians are at high risk of falling into poor listening behaviors. Nichols has identified the following 10 bad habits in listening behaviors that can lead to serious doctor–patient misunderstandings.

1. Dismissing the subject matter as uninteresting. A subconscious resistance to listening may arise if we become bored while listening to complaints that we have heard many times before from many other patients. Effective listening requires attention, patience, and, above all, suppression of the urge to control the conversation or "move it along."
2. Feigning attention. We all learn to look attentive during dull and boring meetings or to appear engaged during conversations that do not interest us. However, feigning attention is risky when talking with patients because they often sense when the doctor is merely pretending to listen and are apt to feel insulted.
3. Losing interest in verbose explanations. The media incessantly bombards us with professionally prepared "sound bites" and "happy talk." This may dull our ability to listen to a patient's often lengthy and unfocused explanations of symptoms that demand more of our active thought processes and time.
4. Allowing distractions. The physician's office environment is characterized by continuous interruptions (e.g., phone, intercom, and fax) that