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Part 1

Communication in health care, and its role in quality and safety

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Introduction: communicating for quality and safety

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Learning objectives

This chapter will enable you to:

- identify the reasons for communication becoming more and more important in health care;
- describe the role of (inadequate or non-) communication in clinical errors and patient complaints;
- list the strategies that have been proposed for improving healthcare communication;
- set out the direct and indirect benefits of good communication.

Key terms

Clinical incident
Complaints
Continuity of care
Patient-centred
Quality of care
Safety of care
Shared decision-making

Overview

In this introductory chapter, we talk about why communication is so important in health care. Indeed, we believe that communication is central to safe and good quality health care. We know that for many people communication is something we do naturally. It is taken as given, and not considered worthy of very much attention. People may also think there are more urgent things to worry about, such as technical precision, clinical knowledge and professional skills.

Communication has been defined in different ways. A recent NHS document defines communication in these terms:

> Communication is a process that involves a meaningful exchange between at least two people to convey facts, needs, opinions, thoughts, feelings or other information through both verbal and non-verbal means, including face-to-face exchanges and the written word. (National Health Service, 2010)

The above definition of communication suggests that communication takes place face-to-face, non-verbally and in writing. We know, however, that communication also increasingly relies on information and communication technologies (ICTs). ICTs harness all kinds of visual and numerical information, as well as language. Further, communication can occur according to well-established formats (procedures or checklists), but it can also move through channels that can be quite hidden and hardly perceptible, like machines talking to one another and initiating actions on the basis of pre-set instructions. In this digital environment, communication is bolstered by a seemingly infinite number of channels (reaching right across the globe), resources (real-time communication as well as historic records) and genres (training clips, speeches, documentaries, publications).

And yet it is becoming increasingly clear, too, that ineffective *in situ* communication can defeat high levels of technical precision, knowledge and skills. For example, a missed medication may undo the success of a surgical intervention. Equally, and by contrast, effective *in situ* communication can alleviate the adverse effects of inadequate knowledge and skills. For example, clinicians and patients are able to help and support one another through communicating about the details of care. For this reason, *how* health professionals communicate with their patients and with each other is becoming an increasingly prominent issue for policy-makers, managers, patients, and for health professionals themselves.

Why is this so? Think back to your own encounters with your health service when you or a loved one were a patient. Think about how people communicated with you, and how you felt about it. You may fondly remember clinicians communicating with you in a way that showed interest and made their care memorable. They took you seriously and looked after you by communicating about matters in ways that involved you and made you feel they took time to understand you as patient. Decisions made sense, conversations were considerate and respectful, and the care felt safe.

You may also have witnessed quite hurried conversations by what appeared to be doctors at the end of your or your relative's bed, or nurses huddling and talking in quiet voices and in a language that was difficult to understand. Different clinicians may have come past in quick succession, all addressing issues whose purpose or relevance was not immediately clear to you. Decisions may have been made in ways that were surprising, contradicting prior decisions and plans, ignoring previous information, or plainly not intended for you, or your relative, but for another patient altogether.

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These examples make clear the following principle that anchors the chapters in the present book: *in situ communication is where care happens in the first and last instance.*

Of course, care happens in many other things that clinicians do with and for patients. Normally, however, communication precedes, accompanies and follows on from clinical actions and interventions. But communication establishes bonds and renders those care activities understandable. Research has shown that effective *in situ* communication is critical to patients' healing. Achieving such effective and healing communication across a variety of settings is what this book is about.

While perhaps not always an immediate cause of an incident or an injury, inadequate communication can render care unsafe or counterproductive. Such care can limit your comprehension of how a health service works, of what you're supposed to do as a patient or a clinician, or how you're to respond to clinicians' advice. For all these reasons, communication plays a central role in how we enact healthcare practices and relationships.

So these are the three principles that are at the heart of this book:

1. communication is where care happens in the first and last instance;
2. communication goes beyond ensuring that the clinician–patient interaction is empathetic and informed, as it encompasses processes that enable and encourage the patient and clinician to discuss both the personal-treatment and the service-organisational dimensions of care; and
3. communication is therefore at the heart of healthcare service quality and safety.

Because communication is where care happens in the first and last instance, and because communication structures care practices and relationships, the quality of communication determines the quality and safety of care. Quality is concerned with whether patients are satisfied with the care they receive. Patients' safety is concerned with the absence of unintended harm, and with making patients feel safe. While health care is more able to conduct invasive procedures nowadays than in the past, the more frequent use of dangerous technologies, treatments and medications, and the increased reliance on institutional and cross-specialty collaboration, have made health care more complex and more dangerous than ever before, rendering patients' safety a critical concern. First and foremost, clinical decisions and actions are safe and of high quality thanks to not only technical skill, but also principally to effective, respectful and attentive communication.

Communicating for quality and safety

It appears that, in most domains of life, we communicate with more people and more frequently than we used to in the past. We may be listening to someone speak and typing a text message on our phone at the same time. Or we may be partaking in a teleconference while reading an email and leafing through a report. One important reason for this intensification of communication is that there are now more channels of communication. Many of these channels can operate simultaneously: talk, text, vision. These various channels of communication inform us about different things, at different speeds, and in different formats. Aside from communicating what others do elsewhere, these channels also increasingly provide feedback about where we are and what we do ourselves: they may tell us where we are located geographically, or how we are performing against a particular benchmark.

While it might appear that all this communication and feedback help make life easier, it actually makes life more complex. We are invited to rethink what we are doing more frequently. We are encouraged to ask more questions about more aspects of who we are and what we do than occurred in the past.

Health care has not remained immune to this intensification of communication. We are now in email contact with our general practitioners (GPs) and specialists. We may have their mobile numbers. When we visit them they will be using computers that display test results and diagnostic reports. When we are admitted to a ward as a hospital patient, we can liaise verbally with ward staff, we can Skype with family, and we can post messages on PatientVoice, a website that enables patients to post comments about the care they receive. Professionals will liaise using mobile phones, email, and a host of other ways of communicating: electronic records, video- and teleconferencing, Facebook, and so forth. The care that patients receive, seek and request is increasingly influenced by and structured around these new channels of communication.

The speed of connection and communication has changed what it means to be a patient and a professional. Patients are increasingly communicatively engaged, even if at the moment a large proportion of patients still expect their healthcare professional to make decisions for them.

Professionals are having to make a greater effort to communicate with patients who come from a greater range of socio-cultural backgrounds: people have less in common and less can now be taken for granted. To counteract this reduction in shared socio-cultural values and practices, **patient-centred** care has now become the new standard. This means acknowledging we need to communicate with individual patients to establish what they want and need. Professionals are also increasingly having to reflect on how they communicate with their colleagues. Hierarchy and status are becoming less viable resources for deciding how to speak with people.

patient-centred
putting the needs of the patient at the centre of processes and priorities.

Problems in healthcare communication

Only about 50% of patients recently surveyed by the Commonwealth Fund in the US feel that their doctor spends enough time with them. Consider Figure 1.1, which is taken from a recent Bureau of Health Information (New South Wales) report. The figure shows the approval rating of how long Australian medical staff spend with their patients (60%) to be level with UK and US ratings:

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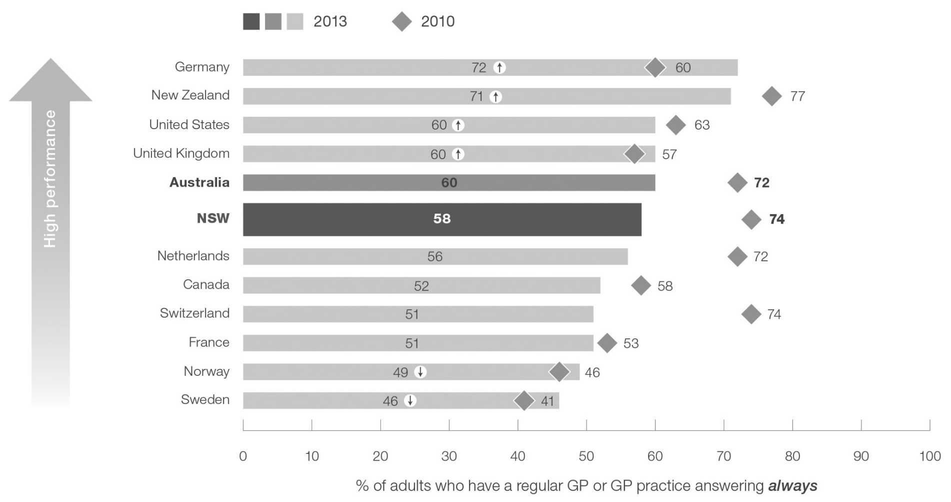

Figure 1.1 *Commonwealth Fund survey 2010 and 2013* When you need care or treatment, how often does the regular doctor/GP or medical staff you see spend enough time with you? (BHI, 2014)

Of interest here is that the 2013 approval rating of Australian and New South Wales medical clinicians is considerably lower than its 2010 equivalent. Does this mean patients are becoming more demanding? Or are doctors becoming busier?

Now consider Figure 1.2. This figure shows that a slightly greater percentage of patients (67% in 2013) find their doctor easy to understand. But this percentage too is down from 77% in 2010.

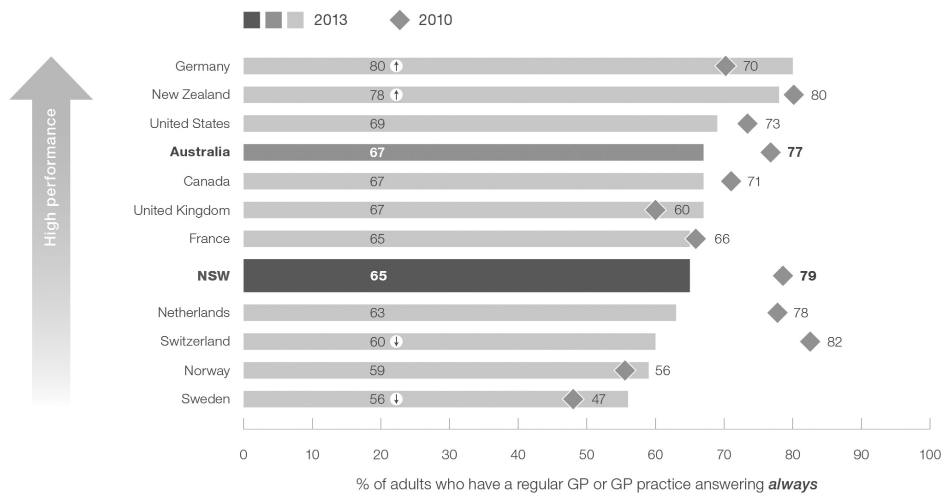

Figure 1.2 *Commonwealth Fund survey 2010 and 2013* When you need care or treatment, how often does the regular doctor/GP or medical staff explain things in a way that is easy to understand? (% answering always) (BHI, 2014)

Why is this so? Does the lower 2013 percentage result from rising patient expectations? Or is it because more patients and practitioners have arrived from overseas, needing to work harder on clear explanations? And what might explain patients' view that only in about 53% of cases their provider 'always knows' their medical history (Figure 1.3)? Could this be an effect of greater 'patient mobility' – do patients move house, state and country more often? Could it also result from the growing amounts of information that practitioners need to gather and process? And what might be the effect of the rising complexity of patients' diseases, now that more people are chronically ill, and also more often now have multiple diseases, or 'co-morbidities'?

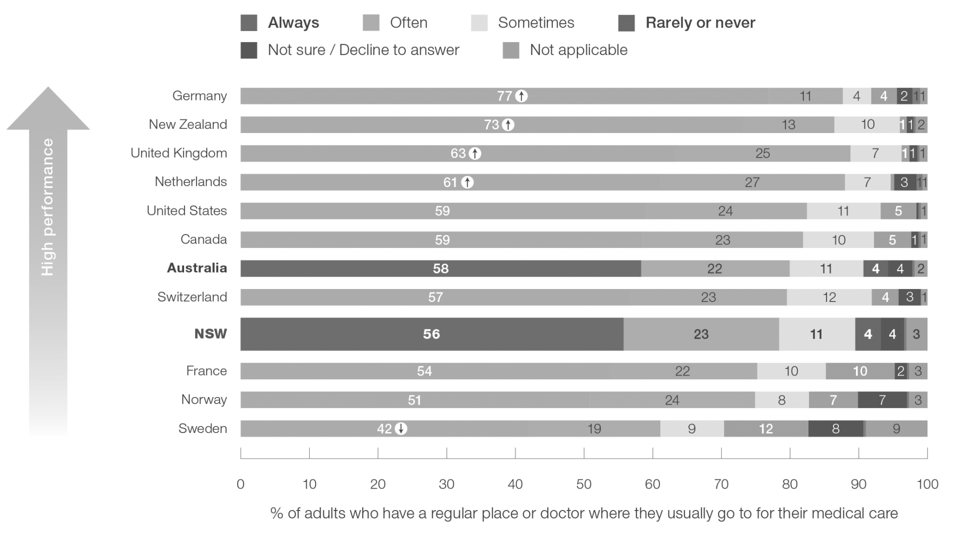

Figure 1.3 *Commonwealth Fund survey 2013* When you need care or treatment, how often does the regular doctor/GP or medical staff you see know information about your medical history? (BHI, 2014)

When we look at health care from the perspective of what patients complain about, we also note that shortcomings in communication are high on the list (Robins, Fasih & Schweitzer, 2014). A review of 59 studies reporting on a total of 88 069 patient **complaints** found that one of the two primary factors underlying complaints was communication (the other being treatment problems (Reader, Gillespie & Roberts, 2014)). For patients generally, good, open and honest communication has been found to be a critical component of effective care (Iedema et al., 2011).

complaints
a person's expressions of dissatisfaction with care services received.

We can also look at healthcare communication from the perspective of healthcare incidents, or care gone wrong (see Chapter 22). Here it becomes even more apparent that inadequate communication creates high levels of dissatisfaction and tension (Sutcliffe, Lewton & Rosenthal, 2004).

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Furthermore, a number of studies have now shown that inadequate communication itself may cause communication failures, and that these failures have real consequences for patients' health: they *harm* patients (Iedema et al., 2008). Much of this communication harm has been shown to be avoidable. For example, more effective ward round and clinical handover communication contributes to avoiding communication failures. A study of Danish incident reports revealed that 52% of the incidents identified in a review of 84 error investigation reports were caused by 'avoidable communication problems' (Rabøl et al., 2011). This finding that inadequate communication or non-communication is a prominent cause of patient harm in health services, particularly for patients from linguistically and culturally diverse backgrounds, is now a common one (Gu, Itoh & Suzuki, 2014; Siu, Maran & Paterson-Brown, 2014).

For patients who come into care with communication challenges due to mental health issues, speech disability, dementia or delirium, the situation is markedly worse still. They have a 46% higher chance of experiencing a clinical error (Bartlett et al., 2008). We address each of these challenges in the chapters that follow.

Improving healthcare communication

The Commonwealth Fund and New South Wales Bureau of Health Information data presented above were derived from surveys asking patients for feedback. In the not-so-distant past, these kinds of feedback were rarely sought from patients. Patient feedback surveys have become prominent only in the last decade or so (Jenkinson, Coulter & Bruster, 2002). Patients' views on their care and on how practitioners communicate with them are considered increasingly important (Weissman et al., 2008). Regular patient satisfaction surveys are now done across Western industrialised countries, a trend that was started by the Picker Institute in the UK (Jenkinson, Coulter & Bruster, 2002). Many government agencies now use 'patient trackers' or on-the-spot feedback surveys using electronic tablets which communicate with a central database that can process thousands of surveys at a time.

But understanding how patients are experiencing care is only one side of the coin. The other side of the coin is how we address the communication shortcomings that patients help us identify. In recent years, a range of strategies has emerged for ensuring that clinician–patient communication improves. One is 'informed consent' (Chapter 14). Informed consent ensures that clinicians ask patients for permission before they initiate treatments. Likewise, **shared decision-making** is a strategy that calls attention to the importance of clinicians sharing decisions with patients, rather than imposing decisions on them (Chapter 12). A much more recent initiative is 'open disclosure', a policy that requires clinicians to be open and honest about mishaps in care (Chapter 22).

shared decision-making
decision-making in which patients and clinicians make treatment plans and decisions together. Shared decision-making discussions take account of best scientific evidence available, as well as patient's values and preferences.

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The reason communication is now considered so important is not just that patients are becoming more assertive about their rights, less tolerant of problematic service standards, and more vocal in their criticism of inadequate health care. Better communication is needed not just to satisfy patients' 'service expectations' but is also critical to delivering good care, to minimising avoidable readmissions, and to maximising patients' ability to manage their own care.

The centrality of communication to care is due to the rising complexity of care: more aspects of care need to be negotiated 'on the spot'. Complexity means this: events have many different dimensions, events are less easily categorised and acted on than they were before, and more communication is now necessary to determine what to do next, even if sometimes events can pose 'wicked problems'. Wicked problems are problems where there is no easy solution. In these circumstances, stakeholders need to be given the opportunity to come to terms with the 'size' of the problem, with the potential lack of a solution altogether, and with the kind of compromise solution that may need to be adopted. The 'wicked problem' described in practice example 1.1 exemplifies what we mean.

Practice example 1.1

A 'wicked problem' – a palliative care patient in an Australian teaching hospital[1]

While still living at home, a 78-year-old female patient is under palliative care treatment at an Australian teaching hospital. Last week, she needed to go into hospital as her lungs have been filling with fluid and she was finding it difficult to breathe. This was her second visit to the hospital in two weeks. This is how she talks about what happened: 'My palliative care doctor happened to be away last week, [since he was] having a minor operation, so no one really "owned" me when I arrived on the Tuesday.' I identified that she felt like a medical orphan.

For an unknown reason, possibly as a consequence of her own doctor being away, the hospital staff took three days to determine that a drain should be inserted in one of her lungs instead of just draining it. The drain would help solve her breathing problem, and would mean that she didn't need to keep coming back for treatment. Before the procedure on the Friday morning, she was 'nil by mouth' (fasting). At about 10:30 a.m., they took her down to surgery, prepped her, covered her with green sheets and placed her lying on her side. This meant she was lying on the leg which had the tumour that was in fact the cause of her impending death, and the pain it caused had been treated with morphine for quite some time. She was left lying on the tumour for an hour. She was in agony, she said. No one was aware of her agony, and no one explained to her what was happening.

Then, suddenly, there was a mad flurry and someone came to tell her that 'they couldn't find a drain'. It seemed that the person whose job it was to check 'the equipment' in question had not done so.

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Practice example 1.1 continued ›

Next, a number of senior doctors came and spoke to her and 'explained' how they were getting in touch with the drain supplier. They expressed regret, but did not apologise to her. They explained the mishap again, and they also said that 'they themselves were very shaken by the whole experience'. After that, a nurse dressed her and returned her to her room.

Then at 4 p.m., she was once again wheeled down to surgery. Once there, she was left waiting for another hour, during which time no one communicated with her about what was going on. Eventually, at 5 p.m., she was given another anaesthetic and the operation commenced. The surgeons and anaesthetists had decided to give her not a local but a general anaesthetic, due to the patient's now highly stressful state. The drain insertion operation went well.

The patient had been nil by mouth since that Friday morning, and, following the surgery, she was not given dinner. The following morning, the Saturday, she was not given breakfast. She had now gone without food for more than 24 hours. Only after she created a fuss requesting some food was she brought something to eat.

The vignette in practice example 1.1 highlights communication to be critical to at least three important dimensions of care:

1. **continuity of care:** There was inadequate handover between the treating physician (who went on leave for an operation) and the clinical team receiving the patient on the Tuesday. This omission resulted in care discontinuity: the patient's treatment and management took two full days to be worked out.
2. **quality of care:** The patient was not given explanations, she was kept lying on her tumour, causing excessive pain, and she was not fed from Thursday night until Saturday morning, when she was finally obliged to ask the clinicians for food. Each of these three problems detracted from the quality of her care.
3. **safety of care:** The palliative care doctor had not left adequate instructions to the clinicians taking over from him, raising the risk of an inappropriate decision being taken. In addition, the surgical equipment had not been inspected before the patient's operation, and the anaesthetic procedure was changed from local to general due to the patient's raised anxiety. Each of these latter three problems are safety problems.

continuity of care
care such that the patient does not face avoidable delays, cancellations and other access barriers; continuity results from practitioners ensuring that their care integrates with the care provided by colleague practitioners.

quality of care
refers to whether healthcare services provide the right care at the right time to the right person, achieving the best possible outcomes for those people every time they come into contact with the healthcare system.

safety of care
the prevention of errors and adverse effects resulting from care provided to patients.

In all, had the clinicians communicated more effectively and attentively, with each other as well as with the patient, every single one of these problems could have been avoided. The palliative care doctor knew the patient was going in for elective surgery and