COMMUNICATION: AN ACHILLES HEEL

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During the span of my career, much effort has been directed toward improving the quality of medical care for our patients. We have guidelines for virtually every medical procedure. Medical outcomes are made public and accessible to help patients make informed choices. All hospitals have committees to create measures that improve the quality and delivery of care. Yet the one positive change that might trump all others remains an elusive and stubborn problem: appropriate and timely communication, both verbal and written.

I was trained to call the referring physician and write a follow-up report after seeing his or her patient. I was trained to communicate with my patients and address their concerns. Prompt and thorough communication was simply a given, a matter of proper medical courtesy.

It may seem simple, but when the most basic etiquette is discarded, it is often the patient who has the most to lose. The idea that every patient needs a medical advocate was endorsed when I was a medical student, and it holds true even more so today. Some say no one physician can possibly follow all the innuendos of modern medicine and that the generalist has been left behind. That's nonsense. The physician's role is not to know it all but to sort it out, collaborate with referring physicians, make judgments, and clarify issues. If a physician can't do that, how in the world is a patient expected to do so?

As a cardiologist in the midst of a rapidly aging patient population and a diminishing supply of family practitioners and general internists, I find myself assuming the advocate role more and more. I suspect many of our readers do, too. In that role, I am constantly baffled that others on the health care "team" who consult on my patients do not contact me with their assessment. It's not just an issue of medical etiquette. It's also an issue of safety.

Communication has become more complicated today with the presence of hospitalists, PAs, NPs, residents, fellows, and sometimes all of the above, at the same time, taking care of the same patient. When speaking with physicians around the country, it's not infrequent that I hear of patients being admitted with a problem and seeing multiple consultants who rarely talk to each other. And even if they do, they often leave illegible chart notes — a formula for error and a measure of quality of care. Patients may get transferred from one service to another and discharged to someplace other than home, and the admitting or referring physician may never hear of that patient again. It sounds impossible, but it is a reality. In an article published earlier this year in the *Journal of the American Medical Association*, Dr. Michael D. Stillman reports his experiences with these same scenarios, each of which resulted in serious consequences for his patients.[1] He writes, "Most of us, given time to reflect, would consider it disrespectful to dramatically alter a patient's regimen, to operate on him, or to fill out his death certificate without first calling at least one of his primary physicians. Yet such behaviors are so common in modern practice that many of us may no longer even notice them."

The idea of having one physician oversee the care of a patient may sound old fashioned. But so often in today's hospital population, patients are older, have multiple problems, and are seen by multiple specialists. The situation cries out for someone to manage their care and coordinate communication with their medical team. That ideally should be the role of the family practice physician. In my experience, however, those physicians are becoming extinct. Medicine has become so specialized that even the specialists are specializing, leaving no one to direct a patient's overall care.

Cell phones, blackberries, pagers, e-mail, instant messaging, text messaging, PDAs, electronic medical records, and the old-fashioned telephone line should be making it easier than ever to communicate. Prompt and thorough communication would save precious time and likely prevent uncountable errors in management. Unfortunately, that time is not recompensed as is when communicating with lawyers, whose time clocks start the minute they pick up a phone. If and when "bundled" Medicare payments become the norm, it wouldn't hurt to have had a little practice in timely communications.[2]

At the Methodist Hospital, efforts are underway to address these issues. Our graduating residents receive literature addressing medical etiquette, principles of leadership, and communication skills with the hope that some of the information sticks. The Methodist Hospital Education Institute is initiating courses on all aspects of medical communication to improve our communication culture. Our medical staff president arranged for every physician to have a personalized stamp to use on all written material beside his/her signature. Our own cardiology practice group employs

e-mail, cell phones, and faxes to notify each other of important transfer and discharge information, and I badger them at every opportunity to be leaders, not laggards, in communication.

If you want to improve your own communication skills, ask your patients how well their physicians communicate with them. You may not like what they say. To patients, we often speak a foreign language. They may hear us, but they frequently don't recall what they were told by the time they get home. This is why it is important that patients have another set of ears when it comes to their care — why diagrams, pictures, literature, and solid communication go a long way towards increasing understanding and easing their stress. It's often the little things done for patients that make one a great doctor in their eyes.

Progress may have ushered in an era of convenience, but communication — with both patients and medical colleagues — should never go out of style.

To learn how your communication skills rate with your patients, the American Medical Association has developed a tool kit called "Improving communication – improving care" that can help boost patient comprehension. Visit www.ama-assn.org/ama/pub/category/18225.html.[3]

REFERENCES

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2. *Hackbarth G, Reischauer R, Mutti A. Collective accountability for medical care — toward bundled Medicare payments. N Eng J Med. 2008;359(1):3-5.*
3. *Organizational assessment toolkit page. American Medical Association Web site. Available at: www.ama-assn.org/ama/pub/category/18225.html. Accessed Aug. 7, 2008.*