

VIEWPOINT

VOICES IN CARDIOLOGY

Communication Skills

The Art of Hearing What Is Not Said



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Communication is part of human behavior that allows societal survival. The hospital is a small structured society that relies on an organized system of communication to function. The patient remains at the center of this micro-society. In this paper, we divided communication skills into 3 parts: between the physician and the patient; between the physician and the family; and between health care providers (Figure 1). The ultimate goal of all these connections is to guide the patient toward health, wellness, and comfort.

COMMUNICATION WITH THE PATIENT

The goal of any communication with the patient is for the physician to learn the patient's experience and facilitate improving their well-being. Communication is the foundation for obtaining medical history, as well as conveying a diagnosis and treatment plan. Good communication skills by physicians have been shown to improve patient satisfaction, adherence to therapies, and to reduce the likelihood of malpractice claims (1-4). Establishing a trusting relationship with common goals is critical for mutually beneficial physician-patient interactions.

Patients are in a vulnerable state because of their illness and expectations to share intimate details with their physician. Their comfort stems from the perception that the physician is empathetic, competent, and genuinely interested in their well-being. Components of effective communication with the patient include meeting at eye level, maintaining eye

contact, and demonstrating affirmative gestures. Speaking slowly and avoiding distractions goes a long way to capture the patient's attention and build rapport with the patient in an otherwise busy and often chaotic clinical setting.

When meeting with a patient for the first time, it is important to assess what the patient already knows and determine what they would like to learn. Although some patients prefer general descriptions of their disease processes, others may want to delve into primary literature upon which recommendations are based. Beyond this, empathy is a critical component of communication. Patient's symptoms and feelings should never be minimized. A physician should be honest in relaying information, but also remain hopeful for the patient and act in their best interest at all times. Furthermore, admitting when an error has occurred or when there is uncertainty about medical evidence is critical for building a trusting physician-patient relationship.

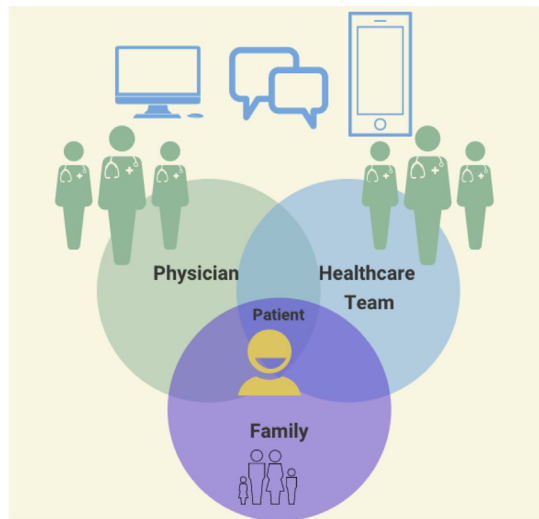
People communicate with gestures, body position, facial expression, and words. With experience, we look beyond oral communication and learn to recognize nonverbal cues to best understand how disease is affecting the patient's life and goals. Train yourself to pick up cues about the patient from the objects that they keep around them and their interactions with their family members. Communication has 2 components, speaking as well as listening. Understand patient's fears and hopes. Be mindful not to introduce your own bias in the conversation and not follow particular stereotypes.

COMMUNICATION WITH FAMILIES AND SOCIAL SUPPORT

Culture is learned and shared, and sometimes there is no conscious awareness of the matter. The first step when communicating with families is to understand the surroundings of the patient. Define the cultural

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FIGURE 1 Communication Skills



Tips to Improve Communication Skills

1. Overall be specific
2. Enhance communication with health care team providers: call, talk face to face, or write your rationale for diagnosis or treatment in the chart
3. Building bridges between disciplines can be productive
4. Understand that it is a two-way street: First listen and then respond
5. When facing death and its frightening meaning, patients/families need time to process
6. First impressions are often lasting impressions
7. Always introduce yourself and the team
8. Enhance communication: Touch (cold hands, sensitive hands, examining patients), hearing (voice tone, volume, speed of speech), vision (observe habits of gesture: small movements of the hands, feet, face, smiles, frowns, fists)
9. Understand cultural background
10. Ask who is with the patient and who is in the room, never assume, can get you into trouble
11. Don't be afraid to say "I don't know", as long as it's followed by "I will find out or find the person who has the information"
12. Acknowledge when you see the patient or family is sad, angry, upset, etc. it goes a long way when the patient and family sees that you understand what they are trying to communicate and may diffuse an otherwise escalating situation
13. Create an environment of psychological safety
14. Learn to love criticism
15. Be humble



Barriers to appropriate communication

- Increasing number of patients assigned per provider
- Health literacy
- Rapid turnover of patients expected by hospital administrators
- Semiprivate rooms
- Time, time and time.
- Illness
- Medication effects
- Cultural differences



70%

Percentage of awake time that an individual spends communicating



25%

Percentage that the listener will remember of a conversation



1-5%

Percentage of negligent adverse events led to actual claims

values and their expectations. Our language, clothing, and mannerisms are the way we express and interact with one another. We work on a daily basis with the terms “illness,” “death,” “love,” and “suffering.” The conscious acceptance of critical illness as part of our daily experience makes our minds adjust to a different reality than that of the individual who is seeing their loved one have a major stroke, heart attack, or die from cardiogenic shock. The normalcy with which we deal with disease may play a role in how we cope as individuals, but this should not disconnect us from the family that we are trying to support. A social support group may be there when the patient becomes sick and can witness symptoms, they may be patient’s caretakers and may ultimately outlive the patient.

The social meaning of disease is interpreted by the personal collected experiences of the individual. Society understands that people are born, may have a disease, and ultimately die. But in many instances, people manage to survive certain maladies. In the current climate we have high expectations for how much should be done for those who are sick. We are at a point where technology has made leaps in terms of care to prolong life expectancy and survival of otherwise fatal disease processes.

We often need to communicate “heavy” news. Under stress, people develop a narrow perception of circumstances. There is often an expected degree of fear and anxiety. The goal is to provide comfort and information. Knowledge can relieve anxieties or instill more fear in individuals. The physician has to be a thermometer of the room and expectations. By simply asking: “what are the expectations?”, the physician may be able to fulfill the need of the patient. Families often undergo the disease process, and they may outlive the patient. Once we start the patient–physician relationship, we may also include their support system, which may be the cornerstone in the disease process of the individual and their recovery.

COMMUNICATION BETWEEN HEALTH CARE PROVIDERS

In the era of ever-growing reliance on technology, electronic medical records (EMRs), and social media, face-to-face interactions are quickly disappearing. Physicians are having “conversations” via EMR notes that are auto-populated with rubbish and get copied forward with inaccurate information. EMRs were meant to take us away from unreadable handwritten notes in paper charts but have actually turned out to

be a step backwards. Clinicians are frustrated by lack of communication among the hierarchical ladder, from interns, residents, fellows, and faculty from service to service. Patient care has a lack of team approach, and physician burnout is on the rise. As medicine becomes ever more complex and treatment requires varying expertise, the days of “cowboy medicine,” when a single physician could effectively care for a patient, are fleeting (5). Medicine is an inherently human profession and experiences the human shortcomings of arrogance, insecurity, and misunderstanding (6). Like everything else we do as clinicians, effective communication requires training, mentorship, and practice.

We divided this section into 3 components: communication between superior and subordinate; communication between subordinate and superior; and communication among team members. Each component requires different sets of skills, and, as we progress in our careers, we must master each one to improve ourselves and provide the best care we can for our patients. We all want to work with competent, motivated, and engaged clinicians. It is important to recognize that achieving that goal is the responsibility of everyone on the team.

SUPERIOR AND SUBORDINATE. Supervising physicians are entrusted with creating an environment that ensures patient safety, fosters scientific inquiry, and contributes to trainee education. There is a fine line between effectively supervising a trainee and micro-managing. By providing trainees with autonomy, we can instill a sense of responsibility, and with that comes motivation to improve. Alternatively, when you take autonomy away, people can feel discouraged from participating in decision-making and not motivated to improve (7). If you do not listen to people around you, you often surround yourself with people who do not have anything to say.

It is important to create an environment of psychological safety (8). Trainees must be comfortable asking questions and proposing incomplete ideas that can be discussed as a group, without fear of being ridiculed or embarrassed. However, psychological safety does not mean a place of no retribution. People should be expected to be held accountable for successes and failures (8). Supervisors must provide an environment that encourages inquiry that is free of judgement, in which trainees are encouraged to ask questions and feel comfortable reporting when something does not seem right, or going frankly wrong. The leader must set the expectations and goals upfront, reassess the progress, and give prompt

feedback and redirection. This approach relieves anxiety, promotes a good line of communication, and improves the care we can provide for our patients.

SUBORDINATE AND SUPERIOR. We all perform poorly from time to time. Whether it is not doing well on a test, taking an incomplete history from a patient, forgetting to include something on a differential, or getting a paper rejected from a journal. It is critical to know how to respond to criticism and constantly look for ways to improve yourself.

Being on the receiving side of criticism can feel overwhelming, paralyzing, and frankly embarrassing. When we hear criticism, our bodies automatically go into a self-defense mode (9). It helps to remember that when someone is giving you feedback, they have already evaluated you and the only thing they are judging now is whether you are open or defensive (9). You have to learn how to love criticism and be prepared to receive feedback. If criticism is sprung on you unexpectedly, your body may retreat to a self-defense mode and not only will it not benefit you, you are more likely to become resentful and avoid the person giving you feedback in the future. Our goal as clinicians is to constantly improve, so we have to change our frame of mind and expect and welcome feedback.

HOW TO WORK EFFECTIVELY AS A GROUP. The complexity of medicine has increased over time. We recognize that whether we are treating a patient with valvular heart disease, myocardial infarction, pulmonary embolism, or cardiogenic shock, we often require expertise from several specialists. We have moved away from individual-based model to team-based models: heart team, valve team, pulmonary

embolism response team, and shock team, just to name a few. However, simply bringing multiple people into a group does not automatically translate into improved outcomes. There are several drawbacks of the team approach that must be explicitly recognized. With larger groups, comes the possibility that individuals may silence themselves for the fear of sounding incorrect, some people silence others by dominating the conversation, and finally, everyone supports the boss's favorite idea (9). We can combat these shortcomings by encouraging participation from all members of the group, especially the quiet ones. We must also foster an environment where incomplete ideas are welcomed for discussion. Communication with other health care providers, including nursing staff, social workers, physical and occupational therapists, as well as pharmacists, will work toward effective patient care and minimize mistakes.

Humility is an essential component of any effective team. We must recognize our own shortcomings, appreciate other people's strength, and give credit where it is due, and put success of the team above personal gain.

Overall, the physician's role is to become an effective communicator among colleagues, patients, and family members to guide the patient toward the path of health, wellness, and comfort.

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KEY WORDS communication skills, healthcare team, leadership, patient care