Disconnected – Systems Issues in Doctor-Patient Communication

By A/Prof Chin Jing Jih

Much has been said and done in recent years about improving the communication skills of doctors. Acutely aware that poorly managed communication problems are frequent precursors of medico-legal problems, hospitals and professional bodies such as SMA (in close collaboration with the Medical Protection Society) have responded proactively by organising a series of communication skills training courses for doctors. In the local undergraduate curriculum, communication skills workshops have become a regular preparatory feature prior to commencing clinical clerkships.

Yet, in spite of this mushrooming of doctor-patient communication courses, we continue to hear about complaints from irate patients and relatives. Such expressions of unhappiness related to clinical communication remain a prominent feature in the work agenda and problem lists of hospital administrators, clinician leaders and patient relations offices, and sometimes, even parliamentarians' Meet-the-People Sessions.

Why then, despite all the training focused on improving doctors' communication skills, are unhappiness and complaints still common?

Part of the answer may be found in the observation that most of these reformative efforts tend to focus predominantly, if not solely, on generic and clinical communication skills. A few, like the communication module of the SMA Medical Ethics, Professionalism and Health Law Course, may take a step further and emphasise the management of challenging communication tasks such as leading family conferences, breaking bad news to patients and handling one's own emotions. But overall, there has been scarce discussion on or attention to possible systemic and environmental barriers to good doctor-patient communication.

One other likely cause is the increasing age of patients today. Most of them are elderly persons who prefer the involvement of family members in decision making, hence delegating to their children the task of speaking to the doctor. Others are mentally incapacitated and will naturally need their family to decide on their behalf. While communication between doctors and patients has improved, the gaps in doctor-family interactions appear to remain, possibly because the engagement is also dependent

on systemic factors such as timing, expectations and the anxieties that come with making decisions for a loved one.

Equipping doctors with the proper skills and technique for effective clinical communication is important, but may be inadequate in addressing some of the systems-related issues, particularly when the targets of the communication are family members. These gaps can lead to dissatisfaction and unmet needs among family members despite the involvement of some of the most professional and empathic doctors.

A grouse commonly expressed by family members is the great difficulty they encounter in just trying to meet the doctors in charge for an update or an explanation regarding the patients' condition. But if the practices and systems in some hospitals are carefully examined, one can begin to understand why some families are convinced that the system is almost intentionally designed to help keep doctors away from them.

For example, while most doctors do their regular ward rounds from 8 am to 11 am, visiting hours in most public hospitals are from 12 noon to 2 pm. While such a system helps reduce disruption to the ward rounds and promotes patient confidentiality, one has to admit that it does not facilitate the families' efforts to meet the doctors in charge for updates and discussion. In some feedback written by a patient's son, who also happens to be a doctor himself, he described his immense difficulties in meeting up or contacting the doctor in charge. He confessed that he had to resort finally to "sneaking into the ward" before the regular visiting hours, in order to "catch the team doctors" for an update on his mother's medical condition.

This is further compounded by a reservation by doctors in general towards discussing patients' conditions over the phone, especially with family members whom they have not met or are unfamiliar with. This becomes an issue if we consider the fact that when no prior appointment is made, it is highly likely that the patient's spokespersons and the doctor will be at different locations when one party attempts to meet in an unplanned way. Communication becomes almost impossible without the use of tools such as the phone.

Sometimes, the most junior doctors are sent by their consultants (who are either in the clinic, operating theatre, meeting room or conducting a teaching session) to update the families and take questions. In complex cases, which is not uncommon among elderly patients today, or in situations where important end-of-life decisions need to be made or conveyed, the risk of an unsatisfying encounter tends to be high due to the inexperience of the junior clinician. And even if the junior doctors were to do a competent job, family members often remain dissatisfied, wondering anxiously if more information could have been conveyed had the clinicians been senior doctors in charge. Some simply hope that the more senior doctors can somehow convert the bad news to a better one. Similarly, suggestions to delegate communication tasks to the nursing staff, who are always present in the ward, suffer from the same issues as above, as worried families today do not rest until they get to speak to someone they regard as having the final authority on the management of their loved ones.

Another source of frustration among family members representing patients is when repeated attempts to get in touch with the doctors in charge, both in person or via the hospital operator system, end up going through one fruitless redirection after another. Those of us who have had similar experiences with banks, insurance companies and customer service help desks can probably empathise. I recall some years ago, how a senior doctor in my department with an exemplary track record in patient communication was absolutely stunned to receive a letter of complaint and threat of litigation from a patient's son, with whom he had a cordial, if not good professional relationship. Prompt investigations revealed that the patient's son, who initially just wanted an update about his mother's condition, became extremely frustrated when he was repeatedly put on hold for long intervals and redirected from one staff to another, but was never connected to the doctor. Again, it is not the skill of the clinician but the system that is found wanting here.

Many complaints are not about a lack of communication skills, but rather, barriers which prevent access to doctors. There is therefore a need for healthcare facilities to start reviewing their systems and processes for possible influence on the families' access to the doctors in charge. For elderly patients whose family members are either decision makers, caregivers or those who are just very worried for their parents, their frustration and anxiety frequently turn into anger and a fault-finding frame of mind when they fail to obtain any information, which are then expressed as complaints and in the worst case scenario, into threats of legal action.

But before we can discuss possible system improvements, all stakeholders need to first affirm the philosophy that effective communication between doctors and family members is a positive and good thing for the patients. Doctors need to embrace a positive perspective towards meeting with family members, and seeing them not as agents who are disruptive to their work, but as essential members of the team working towards restoring health and comfort for the patients. After all, our colleagues in Family Medicine will remind us that illnesses tend to have a significant impact on family members, and conversely, family members can also play a crucial role in the patients' decision making, aftercare and recovery. With the appropriate alignment, it will be easier to consider and adopt some of the practical changes needed to improve the system.

As a start, the current system of visitor management system may need to be tweaked to improve access. One suggestion in some hospitals has been to recognise a key representative or spokesperson for each patient, who will then be allowed to access the hospital ward with minimal restrictions as far as visiting hours go. This may improve the representative's access to doctors in charge and widen the opportunity to meet them.

Perhaps, even more impactful is to move the meeting between doctors and patients' families from a framework based on chance or demand from either doctor or family, to an organised system based on appointment making. With the exception of life-threatening emergencies, a system of fixing a mutually acceptable time to meet will help avoid disappointment and frustration, as well as ensure allocation of adequate time for a fruitful and satisfying meeting. Time and energy wasted on waiting and making enquiries can be minimised. On the other hand, a communication mode based on responding to unscheduled demand or chance is more likely to end up with frustration and in some, anger and an unforgiving predisposition towards the doctors whenever an adverse incident occurs.

Given the busy and tight schedule of both doctors and family members, there is also a need to explore greater use of alternatives to face-to-face meetings, for example telephony or even visual telephony, in an environment which is reasonably secure. The mindset change here is that while personal face-to-face communication is an ideal gold standard, it does not have to be the only standard for exchange of information in this IT age. It is my belief that as long as there is a way to verify the identity of patients' families, say by ward clerical staff, most doctors will be quite happy to communicate using a phone from wherever they are. This will broaden the options available.

One other suggestion is for healthcare institutions to actively develop a culture that embraces good doctor-patient communication as part of its priorities or "core missions". This can include the formulation of institutional policies or guidelines to define an expected "standard of care" for doctor-patient communication with respect to contents and the minimum grade of clinician responsible for different categories of communication. In addition, clinical communication skills can be given due emphasis as a core clinical competency, which is incentivised and given positive acknowledgement. The institution can also invest in physical environments designed to facilitate effective and satisfying interactions between doctors and families, for example family rooms that provide privacy and comfort.

There are indeed many other systems-centric factors that may not be covered by this brief discussion. But I am optimistic that with some awareness and insights of some of these obstacles, and a broadening of focus, healthcare institutions and doctors will find clinical communication much less a chore. On the contrary, it may be the missing link towards experiencing an emotionally rewarding and fulfilling professional experience. SMA

A/Prof Chin is President of the 54th SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.