

The Rhetoric of Healthcare Professionals: Infectious Communication and its Effects

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Abstract

As the need to meticulously simplify healthcare communication becomes a widely recognized epidemic there has been little attempt to describe or reduce the literacy demand of health care dialogue. Healthcare exchanges between patient and provider serve as the cornerstone for successful completion of treatment and with an exceedingly diverse population, providers and patients face numerous challenges. With health literacy's widely complicated nature, the continued low health literacy of patients creates dilemmas that can highlight the providers' pedagogical deficiencies. Palliative illness more often than not demonstrates the deep sensitivities of planning for end of life care and the rhetoric that providers need to be able to handle in their everyday care. This article attempts to review some of the central ethics of communication by encompassing both the provider's due diligence and the patient's understanding.

Good news is a rare commodity in present-day medicine, which makes bad news all the more inevitable. How bad news is delivered can considerably alter a patient and their family's hopes or fears. Sensitive information such as a patient's life jeopardizing illness requires careful communication. There is always a risk, if the manner of communication is less than clear and if patient concordance is not checked regularly during the conversation, a false sense of hope might be mistakenly conveyed, especially in cases where there isn't any hope.

Keywords: Communication; Healthcare; Simplification; Treatment; Incoherent.

The evidence base for adequate communication has recently become more recognized as a means to improving patient understanding and consequently outcomes. This case is best demonstrated in Primary Care where enhancing understanding of a chronic disease such as Asthma or COPD via a care plan can reduce exacerbations and hence time in hospital. There is therefore a health economic advantage to clear communication.

It is highly likely that a doctor will use at least one unfamiliar medical term in any given visit [1]. Healthcare providers in the absence of focused training, may simply lack knowledge on how to go about handling these situations and are unaware of the damage they can cause. There is a considerable amount of gray area in patient-provider communication within the scope of practice, which speaks volumes to the issue at hand [2]. Additionally, in previous years, there has been a push to try and develop an outline or at least some guidelines for communicating with ill patients, but healthcare professionals persistently argue that patient groups are too diverse to be generalized in such a fashion. The predominant problem for patient-provider communication is that each patient is different from the next and this has severely delayed the formation of guidelines or even a clear outline that healthcare professionals would be willing to put to use [3].

Despite this clear disadvantage, teaching centers have taken it upon themselves to create information leaflets as a means to safety netting. Fortunately for most patients, the information is readily available online.

If healthcare were a roller coaster, patient-provider communication would be the safety restraint. When the safety restraint, or in a patient's case communication, is present and working properly, it can make a person's experience much less frightening, but on the other hand, the same person may not want to get on the ride at all if the safety restraint or communication is missing. Analyzing some studies from colleagues in direct reviews of the AMA (American Medical Association) and select US hospitals reveals that providers often unintentionally sugarcoat a patient's condition to try and help them get a grasp on their situation [4]. Not only is down playing a patient's disease misleading, it prevents patients from understanding the full scope of their problem [4]. Offering a white lie to make a friend who cooks for the first time feel better is relatively harmless; in medicine, however, it can falsely convince a terminally ill patient that their predicament is not too serious. Full disclosure helps a patient come to terms with their situation and results in more positivity during prognosis [2], a positive attitude towards a prognosis also ties directly into essential discussions about end-of-life preferences. Contrary to popular belief, if patients acknowledge the possibility of dying and fully understand their condition, their quality of life towards the end of their time fares significantly better [2]. Higher integration can lead to more time for the essential end of life decisions such as will writing, monetary considerations, and even last wishes.

A major disconnect in communication occurs when healthcare professionals presume that patients prefer not to talk in depth about their condition. Through a study conducted by fellow healthcare practitioners in the UK, it was reported that 84.9% of 1046 patients, all of whom had palliative illnesses, wanted as much information about their situation as possible [3]. A similarly complementary study conducted in the US showed that regardless of whether it was good or bad news, 93% of palliative patients wanted full information about their disease and possible next steps [3]. Both studies had patients throughout a range of age groups and all patients had severe illnesses. The study not only indicates that the vast majority of patients are willing but also eager to discuss their illnesses and prognosis options with their doctors. In fact, when patients realize they may not be able to communicate adequately with their provider, they go as far as bringing someone else who can interpret the information from the healthcare professional and relay it back to them, just so they can fully comprehend their circumstance [5]. When doctors mistakenly leave patients un-informed, patients may not realize that their time is coming to an abrupt end until their condition starts to deteriorate beyond repair. Doctors are not always as good at communicating as they might think and maybe we need to consider if someone else should be breaking sensitive news of this nature to patients [6]. It can be demoralizing for a patient to be uncertain or have unanswered questions about what their life will look like in their remaining years. 'Do no

harm' is one of the oaths that doctors are obliged to take when receiving their white coats. When a patient is unaware of the extent of their illness, not by choice, but because the doctor presumes they did not want to know, the doctor is unknowingly neglecting one of the fundamental oaths of their career.

It seems fair to sympathize with the patients instead of the provider so far, but it is not that simple after all, as any story has two sides. A large scale study in 2007 indicated that 84.9% of patients are willing to communicate openly with their providers, despite this being an astonishing number, there needs to be a consideration for the other 15.1% that have a rather different opinion [3]. Another study, conducted in Scotland, found that elderly Aberdenians tended to express a preference for a quick death without awareness [7]. From this Scottish study, age emerged as a predominant factor in a patient's willingness to communicate, and although this held true for the elderly Scottish folk of Aberdeen, it may very well differ around the world; even the study concludes that younger patients are a lot more likely to openly discuss end of life options. Although it is scary to talk about death, being open and having end of life discussions before the time approaches leads to constructive talk about prognosis, goals, values, and adequate planning. Patients regularly resist the urge to ask the doctor questions because they are afraid of offending the doctor [7]; further still, confused patients tend not to even bother asking for clarification because they are flattered by the provider's notion that they do not need explanation. This is all too reminiscent of students not asking questions in class because they are afraid their question might be 'dumb'; the students miss out on valuable explanations and the patients case they would be blocking themselves from much-needed knowledge of their circumstances. It is thus an important part of the Healthcare Professional's duty to enable removing this barrier.

Communication in healthcare can only reach its full potential when both the patient and provider constructively work towards the patients' healthcare goals and this is only possible with a thorough and systematic approach [8].

Each patient brings a unique circumstance and understandably providers tailor their treatment according to it. The absence of consistency in patient trends proves to be a major obstacle in terms of forming communication habits for healthcare providers, but the lack of a general outline may be contributing to providers' reluctance in taking full charge of communication [6]. Naturally patients have complex and completely different personalities from one another; some can be extremely paranoid when passing by a hospital while others will ask to stay awake during surgery. Regardless of personality, patients prefer to remain in control of their actions and be independent of constant care for as long as possible, but they should not shy away from help when they need it [9]. Healthcare professionals can only communicate with a patient to the degree that the patient willingly lets them. In this rather patient driven outcome, it is important to ponder whether healthcare professionals communicate through some didactic means or sheer experience at the cost of awestruck patients. Unfortunately for providers, with the continued absence of any outside help, learning from experience, good and bad alike becomes the default option. With limited progress

occurring and the constant shift in policies, healthcare providers can find themselves at a crossroads between possibly poor communication or no communication at all [10]. Suggesting a more temporary quick fix for the provider's exceeding dilemma, physicians could distil their messages so as to not cause confusion for the patients; the simpler the message, the easier it is for patients to understand fully [11]. Simplification, however, does not even scratch the surface of a go-to solution; in present-day medicine healthcare providers need to be stringently cautious, especially when trying to use simple language to get a message across [12].

As healthcare professionals continue to search for a middle ground between poor and no communication, they tend to get pushed towards simplification. The flaw with over simplification is that providers can end up conveying a false sense of hope; additional faults are tied to not simplifying enough, since healthcare providers may as well be speaking a foreign language when they start using sophisticated medical terminology. With many pivotal decisions stemming from theirs, it is important to realize that providers are required to be careful with their communication choices. If a patient is unaware that their disease will lead to death they will be more optimistic about treatments and prognosis, in hopes of a better attitude towards prognosis providers often do not convey that an illness is incurable [7]. This would suggest that oftentimes physicians deliberately do not inform patients their death is inevitable, which leads to an incredibly unpleasant surprise later on. This is an incoherent consistency considering that when death is left undiscussed with a patient, patients are misled to believe they will be cured this leaves them in the dark about their predicament. Most writers are quick to blame healthcare providers for communication problems in the patient-provider relationship. This hastiness to point fingers aids the imminent misconception that providers are solely responsible; good communication is a two-way street, and patients are just as responsible for conveying their feelings to doctors as doctors are required by policy to do for them. With no guidelines to follow, an intricate new patient each time, a career at stake for potential mistakes, and education gained solely by experience, we must consider it is an intricate process each time a healthcare provider has to break some crushing news to a patient. A more recent development which has posed yet another barrier is the patient's perception of their condition, often through internet research and self formed ideas on what the treatment paradigm should look like. Demystifying the confusion and replacing it with evidence-based medicine can at times be a daunting task, making clear simple communication all the more important.

Overall, medicine has come a long way from medieval barber-surgeons and temple healing, all the way to patients having the liberty to choose between a variety of treatment options, or even walk away from treatment altogether. It is through open transparent communication that the debate on Assisted Dying led to its legalization in Canada and continues to be discussed in many European Jurisdictions.

One thing that is evident, however, is that the best patient-provider communication arises when both the patient and provider are actively involved and each patient is treated according to their unique predicament; with an issue so delicate, healthcare professionals find themselves hard pressed to propose a solution that would be relevant to every problem. Further research to try and find a beneficial medium between adopting just a case by case approach or a strict outline will hopefully lead to a system that can not only be easily taught to providers but just as easily learned and understood by patients.

Conflicts of interest

The Author declares that there are no conflicts of interest.

References

1. Roter DL. Oral literacy demand of health care communication: Challenges and solutions. *Nursing Outlook*. 2011; 59(2): 79-84. doi:10.1016/j.outlook.2010.11.005
2. Anderson WG, Kools S, Lyndon A. Dancing around death: Hospitalist-Patient communication about serious illness. *Qualitative Health Research*. 2013; 23(1): 3-13. doi: 10.1177/1049732312461728
3. Parker SM, Clayton JM, Hancock K, Walder S, Butow PN, Carrick S, Tattersall MHN. A systematic review of Prognostic/End-of-life communication with adults in the advanced stages of a life-limiting illness: Patient/Caregiver preferences for the content, style, and timing of information. *Journal of Pain and Symptom Management*. 2007; 34(1): 81-93. doi: 10.1016/j.jpainsymman.2006.09.035
4. Dubov A. Ethical persuasion: The rhetoric of communication in critical care. *Journal of Evaluation in Clinical Practice*. 2015; 21(3): 496-502. doi:10.1111/jep.12356
5. Eichorst MK, Allen RS, Halli-Tierney AD, Scogin F, Kvale, EA. Health care communication and agreement and disagreement about symptoms within the context of multimorbidity. *Journal of Social Work in End-of-Life & Palliative Care*. 2015; 11(3): 346. doi: 10.1080/15524256.2015.1116484
6. Thorne SE, Harris SR, Mahoney K, Con A, McGuinness L. The context of health care communication in chronic illness. *Patient Education and Counseling*. 2004; 54(3): 299-306. doi: 10.1016/j.pec.2003.11.009
7. Sanders C, Rogers A, Gately C, Kennedy A. Planning for end of life care Within lay-led chronic illness self-management training: The significance of 'death awareness' and biographical context in participant accounts. *Social Science & Medicine*. 2008; 66(4): 982-993. doi: 10.1016/j.socscimed.2007.11.003
8. Thomas H. Engaging patients to understand and improve their experience of Attending hospital. *Journal of Communication in Healthcare*. 2008; 1(1): 78-87.
9. Chochinov HM, McClement SE, Hack T F, McKeen NA, Rach A M, Gagnon P, Taylor Brown J. Health care provider communication. *Cancer*. 2013; 119(9): 1706-1713. doi: 10.1002/cncr.27949
10. D'Agostino TA, Bylund CL. Nonverbal accommodation in health care communication. *Health Communication*. 2014; 29(6): 563-573. doi: 10.1080/10410236.2013.783773
11. Lynch JA, Zoller H. Recognizing differences and commonalities: The rhetoric of health and medicine and critical-interpretive health communication. *Communication Quarterly*. 2015; 63(5): 498. doi: 10.1080/01463373.2015.1103592
12. Zarcadoolas C. The simplicity complex: Exploring simplified health messages in a complex world. *Health Promotion International*. 2011; 26(3): 338350. doi: 10.1093/heapro/daq075