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EDITORIAL

COMMUNICATION IN MEDICAL PRACTICE - SURFEIT OR DEARTH

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Some twenty years ago concerns were expressed about the standards of communication within the medical profession in the United Kingdom, and the ethical implications of failure in this area (1). Practical measures for improvement which were within the capacity of the profession to introduce were suggested. Since then, profound changes have taken place in the availability of medical information and in the training of doctors, both in developed and developing countries. The sheer volume of information now available by mail, meetings, conferences, courses, mass media, including the internet, tele-medicine and so on, has led some doctors to complain that saturation point has been exceeded, with the dawn of a new era of over-communication. Have such changes led to improved communication within the medical profession and increased public satisfaction with doctors?

Few doctors dispute the need to communicate well with patients and colleagues, and most would claim (correctly) to pay attention to this in the course of their daily activities. Is there therefore cause for concern? The answer to that question is likely to vary among individual doctors, their speciality interests, domiciles and work settings. My perspective is that of a hospital based pediatrician and clinical teacher who has had the privilege during the past three years to work in a teaching hospital in Kelantan. The medical school of Universiti Sains Malaysia (USM) has an integrated, problem based undergraduate educational programme, comparable to that adopted by leading medical schools in developed countries, that incorporates modern information technology. Against this background of institutional achievement, this article focuses on communication in the clinical service area, in the hope of promoting discussion about the present situation, and possible scope for future improvement.

As my observations are subjective and largely confined to hospital experiences, I have tried as far as possible to avoid expressing personal opinions, but rather to raise questions for consideration. In restricting my contribution to clinical practice for reasons of economy, I acknowledge the responsibility of teachers and researchers to promote and facilitate communication in education and research and to address similar information availability/application questions, not considered here. Similarly no slight is intended by omitting allied medical groupings, such as nursing, that depend for their success on effective application of knowledge.

Communication with parent(s) / children

Good communication between doctors and patients (usually parents in paediatrics) at initial and follow-up consultations, and at the bedside, are fundamental to the practice of medicine. Arguably the most desired outcome of an enlightened medical education is that doctors not only acquire knowledge and clinical skills, but also the ability to relate their findings to patients, including actions to be taken and treatment options available, and to respond to questions raised and anxieties expressed with courtesy, sensitivity and respect. Failure in this area affects not only diagnosis and management, but can also result in needless confusion, anxiety and sometimes anger. In the past most official complaints about doctors in the West have been shown to originate from failures of communications, which doctors sometimes dismiss as due to patient's forgetfulness, ignorance or stupidity. As these characteristics are not restricted to patients but may be present in all of us from time to time, the onus is on doctors to be alert to such difficulties and to learn how to anticipate and overcome them.

Unfortunately doctors may not recognise that their communication skills are defective. By analog with car drivers, most of whom consider themselves to be careful, competent and courteous, despite daily evidence to the contrary on the main roads of most countries, a gulf between intention and action may not be uncommon. Some examples from pediatrics will serve to highlight such concerns. Are we as pediatricians sufficiently sensitive to the concerns of parents? Do pediatric staff fully appreciate the impact of common acute illnesses (for example observing a child struggling to breathe during an attack of asthma or croup, or seeing a child twitching and failing to respond to touch or speech) have on parents who have not become desensitised by day to day familiarity with such conditions? Do we include parents in discussions during ward rounds? The use of a foreign language, such as English, immediately excludes many parents, unless steps are taken to talk to them in their own language during or after ward rounds. Are parents always given the opportunity to talk with the consultant looking after their child?

Many reasons have been identified to explain communication failures. Lack of training should no longer be an acceptable excuse as medical schools have given this area priority in recent years, with video-recording of student/patient 'encounters', role playing activities, particularly in relation to the breaking of bad news, practice in informing surrogate parents about common medical problems, including genetic advice, when relevant. Together with regular discussion of ethical issues, these methods are now well established in undergraduate curricula including that of USM. How effective have those approaches been? Have the potential benefits been assessed by periodic monitoring?

Shortage of time available to talk with parents is perhaps the most common explanation. However the use of printed information, for example, on how to recognise and manage a febrile convulsion at home, or the recognition and initial management of an acute attack of asthma, including advice on when and where to seek medical help, reinforces verbal information, and is of proven help to parents. This approach has great potential applicability, but is it fully utilised?

The use of medical terms and unnecessary jargon that parents do not understand is an almost universal failing among post-graduate trainers, that can only be corrected by personal effort and day to day practice. Accompanying and listening to an experienced consultant during interviews with parents, is also of enormous value. (Whether doctors communicate better with parents in their own language than in English during role playing activities, I am unable to judge). Problems are compounded by the view of some doctors that communicating with parents is not strictly a medical duty; treatment of disease, rather than the management of a sick child in his/her family and social context, takes precedence. Such attitudes are difficult to change, but there is little doubt about the value of nurses, nurses counsellors and coordinators, now employed in many speciality and subspeciality settings - premature baby care, oncology, nephrology, genetic disease and so on, in coordinating team activities, and providing information and support to parents and children, thereby sharing with doctors responsibilities for communication.

A western doctor working at USM cannot fail to notice striking differences in the expectations of parents. The accepting (non demanding) nature of most parents of children in Kelantan contrasts with that in many Western settings. Does this passivity affect the likelihood of doctor/patient communication and the transfer of important information? Doctors must take the lead by encouraging parents to voice concerns, and to ask questions relating to their child's illness.

Communications within the medical profession

Clear communication between doctors in relation to medical problems and services which they are mutually concerned with, is essential for the efficient and effective treatment of patients, and the coordinated development of medical services in hospitals and related communities. From a hospital based viewpoint, clear and succinct letters of referral and prompt responses to family doctors, detailed case summaries finalised soon after patient's discharge from hospital, and the ready availability of medical case records of previous admissions, or admission to other hospitals, are a minimum requirement in teaching hospitals such as USM. To what extent are these standards met? How is quality control assured? and, what priority is given to rectifying deficiencies?

The opportunities for interdepartmental cooperation and discussion between members of clinical and laboratory services, for example, is potentially great. Is joint efforts of the kind adequate to ensure that the scope, organisation and delivery of services, the timing and quality of request and reports, and filing in case records, are of an optimal standard? How are defects to the system detected

and remedied against? Case referrals between clinical disciplines must also be in the best interest of patients. How quickly can these occur? and at what staffing level? What are the precise roles of on call staff, including consultants, especially during out of hours emergencies? Is this affected by holidays? How is quality control assured? Even with a dedicated, conscientious work force (equipped with high quality guidelines on the management of the most common serious illnesses that affect children, clear instructions about referrals, and regular audit of performance) short comings are sometimes inevitable, especially during unexpected epidemic ('flu', cholera) or disasters (floods, accidents) that overwhelm available resources. Staffing shortages exacerbate difficulties, which are sometimes inevitable in busy services especially those led by single handed consultants, whose task may then become impossible.

Resource constraints is sometimes put forward as an explanation for poor standards in communication and service delivery. These are often outside the scope of clinical control, as few clinicians are wholly familiar with the vagaries of resources allocation. Even in underdeveloped countries it may be hard to understand the basis for service development. Fully equipped highly prestigious specialty units sited along side critically underfunded and understaffed services, sometimes in the same hospital, are not uncommon. I hasten to add that I have not observed this trend at USM hospital. Whether such imbalance in resource utilisation is an essential step towards progress, or merely a side effect of externally engineered ego-embellishing exercise with elitist connotations, is an open question. Where possible doctors should participate in service development to ensure a rational and balanced approach to the allocation of priorities and funds with patient needs as the main consideration. They must communicate effectively with one another and with management to provide considered departmental and interdepartmental input to service development. Failure to ensure a strong medical voice leads to regression, with predictable adverse affects on patient care. Is this a feature of planning on Malaysia? The apparent lack of contact with management at department level contrasts strikingly with the regular, perhaps excessive, interaction seem in Western countries. Again, communication is the key to progress.

Communication with the public

At the given time the public's perception of the medical profession is likely to vary within and between countries. At one extreme, doctors are placed on a pedestal and patients sometimes behave towards them with exaggerated courtesy and respect. Medical advice is accepted passively and great store is set by what the doctor says. At the other end of the spectrum, trust in and respect for doctors has become eroded. Increased demand on medical services and unrealistic expectations (given that resources are not infinite), fuelled by advances in medicine and increased public awareness of disease an its prevention, has left little tolerance for medical error in those societies with well lubricated litigation machinery. Neither of these extremes is conducive to the highest standards of patient care, the former by removing impetus for change, and the latter by encouraging unduly defensive medicine. It is in the interest of doctors that the public know about the main diseases prevalent in the community, the medical facilities available for their treatment, and how to access medical help, especially in emergencies. The public should be aware of important areas of disease prevention, for example, in paediatrics, immunisation of infants and children, the use of folic acid supplements before and during pregnancy to prevent neural tube defects, and about medical advances that are likely to be introduced: HIB vaccination in infancy to prevent H influenza meningitis and the use of desfeniamine in the treatment of thalassaemia. In addition, the adoption by the public of desirable habits conducive to a healthy life style and reduced prevalence of disease, depends largely on the efforts of the medical profession to inform the populace, both directly and through appropriate health promoting agencies. This approach is gaining ground in Kelantan, and information gleaned by questionnaire surveys on family, social and environmental factors that effect disease prevalence and outcome is likely to be translated into positive initiatives and planned interventions related to diet, recreational activities and smoking prevention.

Some doctors are reticent about participating in health promotion activities that increase public awareness, or of intruding on 'cultural' preferences and attitudes towards health. Strategies to gain the confidence of the public are likely to vary among the different racial, ethnic

and religious groups, because of differing perceptions of needs, and attitudes. A negative attitude to lumbar puncture among parents of Malay children with suspected meningitis is common in Kelantan. Similarly the role of the bomoh in the diagnosis and treatment of sick Malay children, and the use of traditional medicines by both Malay and Chinese communities raises questions about the efficacy of those approaches. What is the health costs of delayed access to conventional medical help? By attributing such preferences to 'cultural differences', doctors do not resolve problems, but instead may brake further inquiry, judging from the lack of enthusiasm among post-graduate trainees to address these issues more fully during time allocated for projects. It is difficult for an outsider to comprehend that communication problems in those areas cannot be overcomed by innovative strategies that aim to change attitudes. These will only take place if doctors are sufficiently motivated to respond to the challenge of creating a more informed and self confident society with which to cooperate in a joint quest to establish optimal health care arrangements at hospital and community levels.

Conclusion

Despite promising to sit on the fence and simply ask questions, I am aware of having conveyed the impression that everything in the garden is not rosy and by informing that a disturbing gap exists between knowledge (information) and its application in daily medical practice. This is not intended to offend those clinicians who work hardest, or to diminish the achievements of others who have promoted information technology in the interest of achieving academic excellence. However academic and clinical attainments do not necessarily run in parallel. Knowledge alone may ensure examination success, but does not guarantee the commitment essential to good medical practice. Is the latter requirement undervalued nowadays in the developed/developing world? The penalty for reduced commitment may be great, but is not a barrier to career advancement. The comment 'computer literate' on a curriculum vitae or reference is likely to carry more weight than the statement 'communicated well with patients and colleagues' - better to record both! How close to infinity, is the career/vocation ratio in medicine? To return to my main theme, communication is a vital ingredient of good medical practice. Success does not require unaffordable resources, but instead, commitment, good leadership, and the setting of examples for trainees and medical students to follow, together with acceptance that the traditional components of medicine - service, teaching and research, are all concerned ultimately with improving standards of patient care and in preventing disease. Appropriately directed, advances in information technology can facilitate the achievement of these ends without the risk of a surfeit or dearth in communication.

Reference

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