

Commentary: Communication: The Most Important “Procedure” in Healthcare and Bioethics

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This commentary centers around why Jason Batten et al.’s contribution entitled “Treatability Statements in Serious Illness: The Gap Between What Is Said and What Is Heard” warrants your precious time and finite cognitive bandwidth.¹ This article dissects how physicians, patients and surrogate decision makers communicate about illness, and uses clinical cases to focus on how we derive meaning within and beyond what is actually said. By examining how physician statements can be variably interpreted, they have provided a simulacrum of the Indian parable where blind men touch different parts of an elephant and reach disparate conclusions.² One feels the elephant’s side and decides it must be a wall, one its tusk and assumes a spear. In the clinical arena this is why one patient can hear that “the chance is one-in-a million” and reply over-optimistically “so there is a chance.” It is why another patient can hear “we are running some tests” and over-pessimistically conclude “so you think I have cancer.”

Batten et al. can add themselves to the list of authors who have highlighted why communication may be the most nuanced, and therefore most perilous, “procedure” in healthcare.^{3,4,5,6,7,8,9,10} This body of work buttresses what may seem intuitive: the ability to speak, but also to listen, is central to building or destroying relationships, and relationships matter. Moreover, there exist vicious or virtuous cycles where communication impacts relationships, and relationships impact communication. Accordingly, communication—including the previously maligned topic of gossip—may be central to what it means to be a human.¹¹ Despite all of modern healthcare’s advances we still use the same ‘equipment’—namely, our voices, our ears and our cognition—to coordinate teams during crises, deliver prognoses to patients, and ‘stick-handle’ more than 150 estimated steps per hospitalized patient per day.¹² Accordingly, clinical medicine may be better understood as a branch of the humanities, rather than the biosciences.¹³ Similarly, an expert clinician can be defined as someone who is verbally adroit, not just manually dextrous.^{14,15,16}

Step one is to accept that the ability to speak and listen is a skill that cannot always be intuited, but can be taught.^{17,18,19,20} Step two is to take responsibility for minimizing communication errors, whether healthcare provider or patient; surgeon or surrogate decision-maker; ethicist or educator. Regardless, healthcare is a useful prism through which to examine wider social phenomena. Communication is the medium through which ideas and reputations thrive or perish. The modern world has de-emphasized hierarchy, and therefore our ability to engage and persuade matters. We cannot always dictate, or predict, how others receive what we say. Similarly, the recipient cannot dictate, or identify, how speakers deliver their messages.^{21,22,23,24} In short, it takes humility and patience for two or more people to successfully exchange complex ideas. In contrast, it takes very little skill to misinterpret or disagree.

Batten, et al.’s work emphasizes why complex medical discussions can be duets, or duels. *Words* are launched from the larynx but *ideas* land in the brain.^{25,26,27,28}

This metamorphosis is influenced by myriad factors including our emotions, willingness, intelligence, social cues, and prior experiences. Notably, conversing about serious illness is even tougher if subjects such as death and disability are considered social taboos, rather than inevitabilities.²⁹ At the risk of speculation, the newer generation of doctors now delivering bad news, and the patients now receiving it, may have grown up more comfortable interacting with two-dimensional screens rather than three-dimensional humans. There may also be less trust of experts, and more opposition to ideas that are unappealing or complex. Accordingly, while it is difficult to be a vulnerable or scared patient, it is also not easy to be a modern-day healthcare professional, or ethicist, or academic. We are all—like it or not—in the communication business. The work of Batten et al. is a laudable effort to understand the mechanics behind negotiating the modern age.

Communication: What Does it Mean?

The United States Supreme Court Justice, Potter Stewart, became famous after arguing that while he could not define pornography, he knew it when he saw it.³⁰ While less titillating, good communication can be similarly difficult to pinpoint. Communication typically refers to how we share meaning, or, more literally, the effort to unite as one. While it may seem ironic to define something as interpersonal as communication using impersonal scientific models, it is useful to have a framework and shared mental model.

Communication is more than just *what* is said. It is a bilateral, often multilateral, process that includes *how* it is said and *how* it is understood, which guides *how* it is responded to.^{31,32,33,34} As a result, nonverbal communication (which includes posture; facial expressions; gestures, and eye contact), as well as para-verbal communication (which includes pacing, tone, volume, and emphasis) are as important as verbal communication.^{35,36,37,38} Breaking down communication into parts is important if there is incongruence between the words used and the facial expression, or the tone or its reception. For example, if we say: “he’s unstable” or “he’s doing fine,” but in a tone that suggests otherwise, then listeners often downplay the verbal in favour of the nonverbal. Alternatively, recipients may base their response upon prior interactions: i.e., “the last doctor didn’t seem to care...therefore all doctors are uncaring.”

Healthcare practitioners should understand that humans really cannot *not* communicate. Failing to say anything can also send its own unintended message. Silence can be misinterpreted as agreement or disagreement, support or disinterest, cooperation or contempt. The patient safety literature has tended to treat silence as dangerous, and to encourage—indeed obligate—everyone to speak up clearly, regardless of rank.^{39,40,41} However, the relationship between speech and silence is complex, especially in situations of power imbalance and hierarchy, such as the doctor-patient relationship, or amongst members of an interprofessional medical team.⁴² Silence can still be golden: it allows time for a message to sink in, and for meaningful questions to germinate.

Communication: How Can we Understand It?

A mechanistic approach explains communication by breaking it into component parts, such as sender-message-receiver. An example is Claude Shannon and Warren

Weaver's model, which was derived from telecommunications, but has been used to explain medical communication.⁴³ In Shannon and Weaver's model, transmitters (i.e., speakers) encode messages and receivers (i.e., listeners) decode them. Challenges to communication highlighted by this model include 'interference on the transmission channel' and 'channel-overload' caused by complicated messages. To avoid overload—which can result in indecision or oversimplification—the receiver must be able to decode the message into usable information.⁴⁴ For example, in the clinical realm, a skilled practitioner will receive data ("his blood pressure is continuing to fall"), but communicate this as practical information ("we have run out of therapeutic options").

Mechanistic approaches, like the Shannon and Weaver model, highlight common sources of "noise" or "interference."^{45,46,47} These include distraction and stress caused by literal noise, by time-pressure, and by emotion. Whether people regard these stressors as a threat, or merely a challenge, affects how they receive information and how they respond. For some it expedites focus and understanding, for others indecision and denial. The emphasis on 'parts' (transmitter, receiver), rather than the 'connections between parts', means that Shannon and Weaver's model does not fully account for relational factors, such as hierarchy.⁴⁸ Second, the characterization of communication as linear and unidirectional (from transmitter to receiver) oversimplifies the back and forth of higher-level communication.

The mechanistic approach also focuses on 'data' and 'information', but does not address the role of 'meaning'. Meaning is derived from, not synonymous with, data and information. Importantly, this is why physicians cannot assume that patients or families share their conclusions.^{49,50,51,52} It is why good communication includes time for reflection and confirmation of understanding. Notwithstanding these limitations, the mechanistic approach is clinically useful. For example, a good communicator invests time minimizing 'channel interference.' This includes finding a quiet place, sitting down, and restoring nonverbal cues by removing their surgical mask. The mechanistic approach also highlights "transmitter-orientated" communication, where it is the speaker's responsibility to be understood, rather than "receiver-orientated" communication where it is the listener's responsibility to unravel what was meant.^{53,54,55}

The mechanistic approach highlights that it is worthwhile to ensure accurate message transmission. One simple method taught in medicine, but just as applicable elsewhere, is the three "C's of communication": cite names (make it clear for whom the message is intended); be clear and concise (avoid jargon or vagueness); and close-the-loop (demand a confirmatory reply).^{56,57,58,59} This last strategy explicitly introduces a feedback or amplification loop. It is why we often ask families to repeat back what we have said. It is also why we include a recap. It is why we encourage patients to bring others along and to talk on the journey home. There are many ways to "close the loop," but as a strategy it confirms that the instruction was heard, understood, and carried out.

A rhetoric approach to communication uses the premise that all communication is social: it takes place in the context of relationships between individuals whose goals, perspectives, and values are partly shared, and partly in tension. Effective communication, according to a rhetorical model, means identifying with your audience in order to persuade them to share your goals, perspectives, and values. For example, a doctor may hint that it is time to switch to palliation. A rhetorical approach would argue that his or her failure resides in his/her manner of delivery,

his/her inability to recognize competing motives, and his/her inability to tailor the communication.

A rhetorical model characterizes communication as having not only the sender-message-receiver components of the mechanistic model (though usually called author-content-audience in a rhetorical model), but two additional key components: purpose and context.⁶⁰ Messages are not constructed neutrally: they are used to achieve a purpose, and are delivered in a social context. In a rhetorical approach, it is the relationships between these parts that determines their effectiveness. Whereas a mechanistic approach works well in understanding how to give and take orders during an acute medical crisis, the rhetorical approach is suited to understanding more socially-complex communication.

A rhetorical approach to communication also highlights the role of genres. These are standardized ways of communicating that are also socially-sanctioned and recognizable. Doctors are taught many genres in the form of acronyms. SBAR (Situation, Background, Assessment, Recommendation) is a communication acronym/genre that originated in military and aviation, and was adopted into health-care.⁶¹ SBAR standardizes communication such that one team member can quickly orient another and get buy-in. For example, during a resuscitation: Situation: "this is Dr X, I need your help now"; Background: "I cannot oxygenate this patient"; Assessment: "We have a failed airway." Recommendation: "We need to insert a breathing tube now."^{62,63,64,65} Genres are powerful because they carry meaning over and above the content. As soon as the recipient recognizes SBAR they can infer the speaker's purpose and fill in any gaps. This illustrates the authors' point: it is possible to convey meaning over and above the literal meaning of words through inferences about the speaker's intension. A modified SBAR can be similarly used in family conferences to explain why the patient is so sick, what the likely prognosis is, and to justify the recommended plan. However, as the authors point out, the greater the gap in shared background, the more likely it is that incorrect inferences will be made.

The best-known acronym for breaking bad news is the six-part SPIKES approach.^{66,67,68} This includes (i) Setting up the interview, (ii) assessing the Patient's Perception, (iii) obtaining the patient's Invitation, (iv) giving Knowledge, (v) addressing Emotions, and (vi) Summarizing and having a follow-up Strategy. While communication about serious illness should not be scripted or robotic, these tools may be especially useful for junior team members, during complex situations, or to maintain consistency between healthcare professionals and during handovers.^{69,70,71,72,73,74}

A rhetorical approach reminds us that communication is dynamic, socially-constructed, and open to dispute. For example, any discussions about limiting therapy may invoke reflex opposition from patients and surrogate decision-makers. This may not be based upon factual disagreement, but rather upon social interpretation. Setting preemptive limits may be construed as giving up or neglect, rather than prudent planning. Regardless, a rhetorical approach acknowledges the power of genres to modify ideas, and to influence actions. Even if it seems distasteful, we sell ideas as much as we deliver words.

Communication: Where Do we Go From Here?

Communication has the power to heal or to hurt. Accordingly, it should not just be left to chance, or to the most junior member. In order to deliver medicine that is

safe, understandable, and caring, we need to disseminate—which is really just another word for communicate—the idea that this is serious business. This means committing resources where necessary, and creating time and space for empathy to thrive. Unfortunately, our society—with its so-called medical-industrial complex⁷⁵—is more likely to default to a focus on technical advances.

Accordingly, it might be useful to consider communication as if it is were a drug. After all, it can function as a ‘placebo’ (i.e., good communication makes things better), or ‘nocebo’ (i.e., bad communication makes things worse).^{76,77,78,79} On the one hand it could be employed earlier in order to mollify ‘symptoms’ such as anger and misunderstanding. On the other hand, like any potent therapy, it might come with warnings on the label. Like a drug, communication is neither one-size-fits-all nor a panacea. It should be administered in the right dosage and at the right time, and tailored to the situation.

George Bernard Shaw claimed that: “the single biggest problem in communication is the illusion that it has taken place.” Accordingly, a very useful medical quote from Marcus Rall and David Gaba—“meant is not said, said is not heard, heard is not understood and understood is not done”—offers a cognitive roadmap as to why, and where, we err in communication. While Rall’s quote was intended for anesthetic teams it is as useful when trying to understand discussions about serious illness. It has also been used to create a communication curriculum along with insights from other high-stakes industries.^{81,82}

In short, good medical communication rarely happens by accident. As an intensive care physician, I hope the future will be less about technology, and more about understanding how humans connect. Doctors will need to relearn that nobody cares what you know until they know that you care.⁸³ Similarly, patient and surrogate decision-makers will need to remember that we cannot always save a life, but we always strive to save a death.⁸⁴ Finally, all people are less likely to remember what was done or said, than they are to remember how they were made to feel.⁸⁵ The danger is that these ideas come across as hackneyed or contrived, instead of the battle cry for a renewed focus on an age-old, quintessentially-human skill.

Notes

1. Batten JN, Wong BO, Hanks WF, Magnus DC. Treatability statements in serious illness: The gap between what is said and what is heard. *Cambridge Quarterly of Healthcare Ethics* 2019;28(3):394–404.
2. Wikipedia [internet]. Blind men and an elephant. [Cited 19 Aug 2018]; available at https://en.wikipedia.org/wiki/Blind_men_and_an_elephant (last accessed 2 Dec 2018).
3. St Pierre M, Hofinger G, Buerschaper C. *Crisis Management in Acute Care Settings: Human Factors and Team Psychology in a High Stakes Environment*. New York: Springer; 2008.
4. Brindley PG, Reynolds SF. Improving verbal communication in critical care medicine. *J Crit Care* 2011;26:155–9.
5. Lingard L, Cristancho S, Brindley PG. Verbal communication during acute medical crises. In: *Optimizing Crisis Resource Management*. Brindley PG, Cardinal P, eds. *Royal College of Physicians and Surgeons of Canada Press*. 2017. [Cited 19 Aug 2018]; available at <http://www.royalcollege.ca/rcsite/documents/practice-performance-innovation/optimizing-crisis-resource-management-improve-patient-safety-team-performance-e.pdf> (last accessed 2 Dec 2018).
6. Cyna AM, Andrew MI, Suyin GM, Tan SGM, Smith AF, eds. *Handbook of Communication in Anaesthesia and Critical Care. A Practical Guide to Exploring the Art*. Oxford University Press; 2011.
7. Brindley PG, Smith KE, Smith, Cardinal P, Leblanc F. Improving medical communication: Skills for a complex (and multilingual) world. *Canadian Respiratory Journal* 2014;21:89–91.
8. Rall M, Gaba D. Human performance and patient safety. In: Miller R, ed. *Miller’s Anesthesia*. Philadelphia: Elsevier Churchill Livingstone; 2005:3021–72.

9. Brindley PG. Patient safety and acute care medicine: Lessons for the future, insights from the past. *Critical Care* 2010;14(2):217–22.
10. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective communication in providing safe care. *Quality & Safety in Health Care* 2004;13(suppl):i85–90.
11. Carey B. Have you heard? Gossip turns out to serve a purpose. *New Yorker* magazine [internet]. 2005 August [Cited 19 Aug 2018]; available at <https://www.nytimes.com/2005/08/16/science/have-you-heard-gossip-turns-out-to-serve-a-purpose.html> (last accessed 2 Dec 2018).
12. Gawande A. The checklist: If something so simple can transform intensive care, what else can it do? *New Yorker. Annals of Medicine section* 10 Dec 2007:1–8.
13. See note 9, Brindley et al. 2014.
14. See note 3, St Pierre et al. 2008.
15. See note 4, Brindley et al. 2011.
16. See note 5, Lingard et al. 2017.
17. See note 3, St Pierre et al. 2008.
18. See note 4, Brindley et al. 2011.
19. See note 5, Lingard et al. 2017.
20. See note 6, Cyna et al. 2011.
21. See note 3, St Pierre et al. 2008.
22. See note 4, Brindley et al. 2011.
23. See note 5, Lingard et al. 2017.
24. See note 6, Cyna et al. 2011.
25. See note 3, St Pierre et al. 2008.
26. See note 4, Brindley et al. 2011.
27. See note 5, Lingard et al. 2017.
28. See note 6, Cyna et al. 2011.
29. Psirides A. Everything at end of life. Lecture delivered at SMACC conference Berlin June 2018 [internet]. [Cited 19 Aug 2018]; available at <https://www.youtube.com/watch?v=jV5ZNbNzIrs> (last accessed 2 Dec 2018).
30. I know I when I see it. [internet]. [Cited 2018 Aug 19]; available at https://en.wikipedia.org/wiki/I_know_it_when_I_see_it (last accessed 2 Dec 2018).
31. See note 3, St Pierre et al. 2008.
32. See note 4, Brindley et al. 2011.
33. See note 5, Lingard et al. 2017.
34. See note 6, Cyna et al. 2011.
35. See note 3, St Pierre et al. 2008.
36. See note 4, Brindley et al. 2011.
37. See note 5, Lingard et al. 2017.
38. See note 6, Cyna et al. 2011.
39. See note 3, St Pierre et al. 2008.
40. See note 4, Brindley et al. 2011.
41. See note 5, Lingard et al. 2017.
42. Gardezi F, Lingard L, Espin S, Whyte S, Orser B, Baker GR. Silence, power and communication in the operating room. *Journal of Advanced Nursing* 2009;65(7):1390–9.
43. See note 3, St Pierre et al. 2008.
44. See note 3, St Pierre et al. 2008.
45. See note 3, St Pierre et al. 2008.
46. See note 4, Brindley et al. 2011.
47. See note 5, Lingard et al. 2017.
48. See note 5, Lingard et al. 2017.
49. See note 3, St Pierre et al. 2008.
50. See note 4, Brindley et al. 2011.
51. See note 5, Lingard et al. 2017.
52. See note 6, Cyna et al. 2011.
53. See note 3, St Pierre et al. 2008.
54. See note 4, Brindley et al. 2011.
55. See note 5, Lingard et al. 2017.
56. See note 3, St Pierre et al. 2008.
57. See note 4, Brindley et al. 2011.

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58. See note 5, Lingard et al. 2017.
59. See note 6, Cyna et al. 2011.
60. Lingard L, Haber RJ. Teaching and learning communication in medicine: A rhetorical approach. *Academic Medicine* 1999;74(5):507–10.
61. SBAR Institute for Healthcare Improvement. SBAR Technique for Communication: a situational briefing model [internet]. [Cited 19 Aug 2018]; available at <http://www.ihi.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.htm> (last accessed August 2018).
62. See note 3, St Pierre et al. 2008.
63. See note 4, Brindley et al. 2011.
64. See note 5, Lingard et al. 2017.
65. See note 6, Cyna et al. 2011.
66. See note 6, Cyna et al. 2011.
67. See note 7, Brindley et al. 2014.
68. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES-A six-step protocol for delivering bad news: Application to the patient with cancer. *Oncologist* 2000;5(4):302–11.
69. See note 3, St Pierre et al. 2008.
70. See note 4, Brindley et al. 2011.
71. See note 5, Lingard et al. 2017.
72. See note 6, Cyna et al. 2011.
73. See note 7, Brindley et al. 2014.
74. See note 8, Rall et al. 2005.
75. Wikipedia [internet]. Medical Industrial Complex. [Cited 19 Aug 2018]; available at https://en.wikipedia.org/wiki/Medical-industrial_complex (last accessed 2 Dec 2018).
76. See note 3, St Pierre et al. 2008.
77. See note 4, Brindley et al. 2011.
78. See note 5, Lingard et al. 2017.
79. See note 6, Cyna et al. 2011.
80. See note 6, Cyna et al. 2011.
81. See note 4, Brindley et al. 2011.
82. See note 5, Lingard et al. 2017.
83. Brainy Quote [internet]. Roosevelt T. [Cited 19 Aug 2018]; available at https://www.brainyquote.com/quotes/theodore_roosevelt_140484 (last accessed 2 Dec 2018).
84. See note 29, Psirides 2018.
85. Author disputed [internet]. [Cited 29 Aug 2018]; available at <https://quoteinvestigator.com/2014/04/06/they-feel/> (last accessed 2 Dec 2018).