Effective communication, the heart of the art of medicine

Parvaiz A Koul

Department of Internal and Pulmonary Medicine, Sher-I-Kashmir Institute of Medical Sciences, Srinagar, Jammu and Kashmir, India.
E-mail: parvaizk@gmail.com

Of the core skills that enshrine the practice of medicine is the physician’s ability to communicate with the patients. A physician’s communication and interpersonal skills involve the ability to obtain information to facilitate the precise diagnosis, counsel suitably, give therapeutic instructions, and establish a compassionate relationship with the patients. Basic communication skills underlie a successful doctor-patient relationship, which essentially consists of shared knowledge, perceptions, and feelings regarding the nature of the disease, goals of treatment, and psychosocial support. Effective doctor-patient communication is thus a central clinical function and is regarded as the heart of the art of medicine. The three main goals of doctor-patient communication include creating a good interpersonal relationship, facilitating the exchange of information, and including patients in decision-making. While these facets of the practice of medicine are stressed upon in evolved health-care systems, where physicians have to deal with educated and generally informed patients, they do not get the same emphasis in developing countries like India where health-care delivery is often replete with inadequate infrastructure and overburdened personnel.

The current issue of Lung India carries a study by Singh et al. where they report the results of an online survey of 1028 pulmonologists across the country regarding the terminology used by them to communicate the names of five common respiratory conditions, tuberculosis, asthma, chronic obstructive pulmonary disease (COPD), pneumonia, and idiopathic pulmonary fibrosis, to their patients in their individual practices. The physician survey showed that about 60% employed correct terminology, with pneumonia being conveyed correctly by 87% of the participants whereas idiopathic pulmonary fibrosis being communicated correctly by only 16%. In the second part of the study, Singh et al. surveyed 1122 patients, who presumably due to logistic reasons, belonged to a single area of the study. Of these, only 17.6% could correctly name their disease, the correct response ranging from 0.34% to 31.9% for various disorders. Since the patients belonged to the study site with the maximum recruitment of the pulmonologists, the authors believe that the results reflect a similar trend across the country. Notwithstanding this limitation, the survey exposes the ineffective communication between the physicians and the patients. It is conceivable that the communication would be even poorer for less common conditions of the respiratory system and is broadly indicative of a serious disconnect between the desired and the actual practice of communication.

The importance of the results of the survey does not simply lay in the exposition of the ineffective and discordant communication between doctors and patients but also in the potential of misleading researchers who collect epidemiologic data on the basis of questionnaire surveys. As pointed out by the authors, this could be the reason for a possible underestimation of the prevalence of chronic bronchitis in the landmark INSEARCH study where the prevalence was reported to be 3.5% compared to much higher prevalence in subsequent spirometric studies. A discordance between doctor-diagnosed COPD and the actual prevalence of COPD in the BOLD study from Kashmir could also be in part be attributed to the inadequate communication of the diagnosis by the physicians to the surveyed participants. Similar conclusions could be drawn about the ISAAC study where the local term, dama, was used for survey; however, the current study showed a positive predictive value of only 33% for the term. The incorrectly conveyed diagnosis can also potentially lead to the initiation of a wrong treatment in the patient by physicians in overburdened public facilities robbing the patients and the physicians of the benefit of an earlier care provider’s efforts.

Physician beliefs and attitudes have modulated their practice of communicating with the patients. In 1950s to 1970s, most doctors considered it inhumane to disclose bad news to patients because of the bleak prognosis for treatment of cancers. Physicians often discourage patients from voicing their concerns and expectations as well as requests for more information. Doctors, not infrequently, lack empathy which partly stems from the emotional and physical ruthlessness of medical training, especially during internship and residency. Techniques and procedures get substituted for a compassionate and informal talk. These attitudes are unfortunately more rampant in burdened health-care systems in most developing countries and only recently have been giving way from paternalism to individualism in developed countries and the current model of shared decision-making.
and patient-centered communication.\textsuperscript{[13,14]} Studies on doctor-patient communication have demonstrated patient discontent even when many doctors considered the communication adequate or even excellent.\textsuperscript{[9]} Doctors tend to overestimate their abilities in communication whereas patients believe otherwise. Tongue et al.\textsuperscript{[15]} in a survey of orthopedic surgeons reported that 75% of the orthopedic surgeons surveyed believed that they communicated satisfactorily with their patients, but only 21% of the patients reported the communication to be satisfactory. The current study by Singh et al exposes a similar scenario in the Indian context.

Times, however, are changing. Today, patients have recognized that they need not be passive recipients of the doctors’ “orders” and resist the power and expert authority that society grants doctors. They implicitly and/or explicitly resist the monolog of transfer of information from doctors regarding their disease and wish to assert their own perspectives, integrate with their knowledge of their own bodies and experiences, as well as the social realities of their lives. Thus, it would be certainly help to know the effects of literacy of the patients as well as the economic status of the patients on the results of the survey conducted by Singh et al. Furthermore, the results of such surveys among others could get influenced by factors such as patients’ anxiety and fear, doctors’ burden of work, fear of litigation, public versus private location of the practice, time per consultation, availability of a nurse/technician, access to a laboratory, fear of physical or verbal abuse, and unrealistic patient expectations. While arguably these factors could interplay with the survey results and as such demand a larger study versus private location of the practice, time per consultation, availability of a nurse/technician, access to a laboratory, fear of physical or verbal abuse, and unrealistic patient expectations. While arguably these factors could interplay with the survey results and as such demand a larger study with consideration of all possible confounding factors, the survey emphatically underscores the importance of effective communication between the doctors and their patients. Use of a standard terminology coupled with other relevant information of the patient’s problem is important so that care is patient-centered and empowers patients with the relevant information regarding their problems and makes them equal partners in the management plan of their illness.

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