FROM THE EDITORS' DESK

A Failure to Communicate

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In the film *Cool Hand Luke*, Paul Newman stars as "Luke," a rebellious prisoner in a southern prison camp. Unable to tolerate the confinement of prison, Luke attempts an escape but is soon captured, returned to the prison and put in chains by the captain who aims to make an example of him in front of the others. Even in this vulnerable position, Luke refuses to give in and talks back to the captain, who, enraged, beats him and utters one of the most oft quoted lines in movie history:

"*What we got here is a failure to communicate.*"

Communication failures are common in medicine, and none more so than when a patient tries to tell his or her story to the doctor (or for that matter, to any health professional). Who better to communicate concerns and wishes than patients themselves? Yet too often, patients bearing insights about their diagnosis are perceived as a distraction. We know from multiple studies that doctors habitually interrupt patients, shortcutting their efforts to explain their concerns; too few doctors have the patience to listen.

Our collective failure to communicate was evident to me again as a result of my father's recent experience accessing urgent medical care. I received a call from my dad, a retired behavioral health care executive, saying that he had moderately severe abdominal pain ("more than 5 out of 10") lasting for several hours, and while he initially assumed that it was a result of the large yogurt parfait he had consumed for breakfast, he thought it was curious that over the course of the morning the pain had moved from the mid part of his "stomach" to his lower right side. As any patient with access to a computer might do, he 'Googled' his symptoms and was surprised to find that according to a popular lay medical website, he most likely was suffering from appendicitis.

After phone consultation with his internist (who incidentally shared his concern), he was off to the emergency department (ED) for what both thought would be urgent triage and evaluation. Instead, with unrelenting right lower quadrant abdominal pain and repeated attempts to communicate with the ED triage staff by saying something unambiguous like "I think I have appendicitis," he was left in the waiting area for several hours with his condition gradually worsening. Realizing that time was running short, he managed to position himself in front of the triage window to demonstrate that he had now developed overt rigors for whoever cared to look in his direction, and was finally brought into an exam room. This communication failure led to a delay in his diagnosis of acute appendicitis, and, according to the surgeon who finally removed his inflamed appendix at 1 AM, any further delay may have been catastrophic.

In this issue of *JGIM*, we feature a number of papers that focus on different aspects of health communication and its importance in the education and practice of general internal medicine. Perhaps no area of physician–patient communication is more challenging than that addressed by Anthierens et al.[1] in a qualitative study from Europe that explores physicians' experiences with training aimed to enhance their communication strategies to reduce inappropriate prescribing of antibiotics for acute bronchitis. They performed face-to-face interviews with physicians from England, The Netherlands, Poland, Spain and Wales who had participated in a large randomized trial to reduce antibiotic prescribing for adults with acute respiratory tract infections. As an accompanying editorial in this issue by Linder[2] points out, antibiotics have not been shown to reduce the severity or length of symptoms for patients with acute upper respiratory infections, so they essentially function as an anxiolytic for the patient and doctor. Anthierens et al. conclude that providing physicians with communication skills training seems to increase their confidence in making appropriate "non-prescribing decisions".

When doctors make decisions about the use of antibiotics for acute upper respiratory tract infections, they usually do so in the face of explicit or implicit requests from patients. There is a robust literature that suggests that patient requests can have a significant influence on physician behavior, and furthermore that patient requests, for better or for worse, are sometimes driven by direct to consumer advertising (DTCA) of drugs and other medical services. In this issue of *JGIM*, Skeldon et al.[3] examine the impact of sequential DTCA campaigns for two common drugs, tamsulosin and dutasteride, for the treatment of benign prostatic hypertrophy. Their main outcomes were Internet search volume for each drug as well as prescription rates. They found that both DTCA campaigns resulted in increased searches and increased prescriptions for both drugs, but that interestingly, both campaigns were associated with greater increases in the use of the guideline-recommended first-line agent (tamsulosin). This study seems to confirm the findings of others; that while DTCA is an effective communication tool that can influence patient and

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physician behavior, it is a blunt instrument that may result in unforeseen outcomes.

And finally, few issues are garnering more attention lately than the importance of team-based approaches to patient care. In this issue, Jones et al.[4] examine the challenges to care coordination for hospitalized patients in a qualitative study of hospital-based and primary care physicians (PCPs) in North Carolina. As might be expected, both hospitalists and PCPs reported numerous challenges to care coordination, both during hospitalization and around transition of care to the outpatient setting. As the authors point out, most of these challenges boiled down to communication failures between PCPs and hospitalists; it seems that too often they were unable, uninterested or unwilling to directly or electronically communicate critical clinical information to one another, undoubtedly with negative consequences for patient care. Interestingly, in this era of more impersonal communication methods such as e-mail and the electronic health record, both groups expressed interest in building and sustaining more personal relationships as a way to enhance professional communication.

And speaking of personal relationships, luckily my dad sailed through his operation, and was sent home to recover after only a few days in the hospital. But his failure to communicate, or more accurately, the failure of the health care team to listen (after all, he was trying to tell them his diagnosis) could have led to a very different outcome. As George Bernard Shaw once said: "The single biggest problem in communication is the illusion that it has taken place." When our patients or our colleagues attempt to communicate with us, or we with them, we should practice our best active listening skills to be sure that the message is heard or received. A failure to communicate in the health care setting is not simply an inconvenience, it can result in delayed diagnoses, unnecessary tests, increased costs, and at times, may contribute to avoidable but disastrous clinical outcomes.

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