

Doctor Patient Communication

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Introduction

Effective communication between hospital staff and patients is essential for the healthcare system to properly function. When patients do not have complete comprehension regarding their health conditions, it is unlikely that the care plans implemented by their health care providers will be implemented in the most effective way. Unfortunately, there is currently not a clear consensus on exactly how the doctor patient relationship should look, which can also lead to different expectations of communication depending on the patient. Thus, the model of communication between the doctor and the patient often depends on the doctor's preference and personal sensitivities.

Barriers to Effective Communication

Implementing effective communication between patients and their health care providers is imperative in maximizing patient satisfaction, adherence, and health related outcomes (Clarke *et al.* 2020). While conveying complex scientific concepts to patients can itself be a barrier to effective doctor patient communication, there are also various external factors that can contribute to difficulties in communication. Such factors include language barriers, culture, and socioeconomic differences. Physicians must be educated about these obstacles and equipped with the appropriate techniques to deliver optimal patient care under such circumstances. Many clinics and hospitals serve diverse populations and it is imperative for healthcare workers in these types of settings to be extra sensitive to communication barriers as they will likely impact many of their patients.

Language Barriers

The number of residents in the United States with a first language besides English has been exponentially growing over the past thirty years. An analysis of census data by The Center for Immigration Studies (2018) found that 67.3 million residents of the United States do not speak English at home. This group amounts to about 21.9 percent of the total United States residents. This percent is more than double that of the 1980 calculation when 11 percent of United States residents were found to speak a language other than English at home. Additionally, in American's five largest cities, New York City, Los Angeles, Chicago, Houston, and Phoenix, about 48 percent of residents speak a foreign language at home. In fact, today there are more residents who speak Spanish at home in the United States than any country in Latin America except Mexico, Columbia, and Argentina. This discrepancy is only increasing. Since 1980, the number of people who speak a foreign language at home has increased seven times faster than those who speak only English at home. Of those who speak a foreign language at home, 38 percent say they speak English "less than very well." In total, that is approximately 25.6 million United States residents. These numbers make it increasingly more likely for healthcare workers and patient interactions to exist where one or both are speaking a second language.

With these staggering statistics in mind, it makes sense that language barriers have arisen as a key issue in healthcare facilities. A study in England collected data from 59 nurses and found that language barriers were the biggest obstacles in providing adequate, appropriate, effective, and timely care to patients (Ali and Watson 2018). Another study published in the International Journal of Nursing Studies sampled 576 ethnic minority patients on 30 wards within four urban hospitals and explored the specific safety risks associated with language barriers. The study found that among the most prominent impacts of language barriers included

medication administration, pain management, and diagnosis communication (van Rosse *et al.* 2016).

Interpreters

The option of interpreters has been well researched and has been found to provide significant benefits as long as proper protocols are followed (Clarke *et al.* 2019). Interpreters play an essential role in communicating symptoms from physicians to patients and communicating diagnosis and treatment plans from patients to physicians. Additionally, interpreters are necessary for conveying the emotional elements between the physician and patient. In fact, studies show that empathy in interpreted consultations is largely dependent on interpreters (Lehane and Campion 2018).

However, not just anyone can be an interpreter. Interpreters are distinct from translators in that they do not convey written language from one language to another, but rather they convert oral language from one language to another. An interpreter must be well trained in both the language and culture euphemisms and mannerisms of both the doctor and the patient. An analysis by Sarah K. Clarke (2019) at the Society of Refugee Healthcare Providers found that it is necessary that the interpreters used are well trained and qualified to ensure transparency and point out cultural differences that impede communication. Untrained interpreters who do not have a deep knowledge of both languages involved can result in errors such as omissions, substitutions, and inaccurate conveyals of medical information (Flores *et al.* 2003). Additionally, untrained interpreters can choose to filter sensitive information.

Having competent interpreters is only part of the equation. Healthcare providers must be trained to work with language service providers as well. A 2010 survey found that 54 percent of

pediatric residents had never attended training sessions on working with interpreters (Flores *et al.* 2003). Not attending such training is the primary reason for underuse of qualified interpreters. Providers must learn to be mindful of their speech manner and content and check in with the interpreter and patient regularly to make sure all parties involved understand what is being communicated.

A 2002 study published in the Australian Health Review explored the interpreter service system utilization in the Melbourne metropolitan healthcare system and found that there is an over reliance on informal interpreters, such as family members and friends, while there is an under-usage of utilization of professional interpreters (Heaney and Moreham 2002). Another barrier that makes professional interpreters underused, logistical issues, arrangement difficulties, availability of access, and convenience, make this option less than ideal (Ali *et al.* 2018). Fortunately, the use of videoconferencing methods can perhaps make these logistical issues more manageable in the future.

Culture and Ethnicity

Culture and ethnicity are prominent barriers to maximum effectiveness in doctor patient communication. A study conducted at Utrecht University analyzed this phenomenon through a literature review using online databases and identified five key predictors of culture related communication problems between doctors and patients (Schouten and Meeuwesen 2006). Firstly, there could be cultural differences in explanatory methods and preferences. Second, differences in cultural values could lead to less effective communication regarding healthcare. Third, cultural differences could lead to different preferences in the structure and model of the doctor patient relationship. Fourth, racism and perceptual biases can have conscious effects on doctor patient

communication. Finally, cultural differences often come with language barriers or linguistic barriers via usage of different types of figures of speech and euphemisms. Due to these factors it is imperative that physicians and patients are mindful and sensitive to cultural differences. A study conducted at McGill University in Canada looked at the challenges presented by intercultural communication recommended that physicians receive some sort of intercultural communication training while immigrants receive some sort of empowerment training in order to promote effective doctor patient communication (Rosenberg *et al.* 2005).

Socioeconomic Differences

The effect of socioeconomic class on doctor patient communication has been widely studied. One such study conducted by Epstein *et al.* (1985) looked at 100 ambulatory patients who underwent echocardiography to evaluate previously undefined cardiac problems. To effectively measure communication, they examined how often the patient and doctor agreed on basic elements of the patient care process including symptoms, test results, therapy, and prognosis. Socioeconomic status was determined by insurance coverage or occupation. The study found that doctor patient communication was less effective when the patient was of a lower socioeconomic status. Additionally, the training of the physician had no effect on the effectiveness of communication, further demonstrating the effect of socioeconomic status on doctor patient communication. It is also interesting to note that physicians were unable to predict when the patients were not properly understanding them.

Another study conducted by Allen *et al.* (2021) looked for differences in doctor patient relationships between different socioeconomic status in patients in head and neck oncology clinics. The study found that patients of a lower socioeconomic status were more passive in their

participation with their healthcare providers and less engaged in agenda setting and information seeking. Patients of a lower socioeconomic status overall took a more stoic approach in their healthcare, similar to Veatch's (1972) priestly model in "Models for Ethical Medicine in a Revolutionary Age." Additionally, patients of a lower socioeconomic status were found to do less small talk and engage in less humor with their physicians than that of people of a higher socioeconomic status.

Similarly, a systematic review by Willems *et al.* (2005) in Belgium found that patients from lower social classes receive a more directive and less participatory consulting style from their physicians. The researchers suggested that the communication style of physicians is influenced by the way their patients communicate. Generally, patients from a lower socioeconomic group communicate less actively and with less expressiveness, eliciting less information from the physician than those from a higher socioeconomic group, who communicate more actively and expressively. The researchers suggest that perhaps more effective communication skills could be established between physicians and those of a lower socioeconomic group. Physicians and patients need to become more aware of the potential roadblocks that prevent maximum effectiveness in their communication through the physicians awareness of contextual communicative differences and by empowering patients to be more expressive and active in their communication.

Technology and Communication

Technology has been found to have significant impacts on communication in healthcare adherence. A systematic review conducted at Warwick Medical School looked at the influence of automated telephone communication systems and their role in healthcare. Automated telephone

communication systems are used in conjunction or instead of telephone conversations between healthcare providers and patients (Eccles and Atherton 2018). The review concluded that there is some evidence that these communication systems can be effective in some cases and increase levels of immunizations in children, improve self monitoring of diabetic foot, and reduce glycosylated hemoglobin in patients with diabetes. Another study conducted at Imperial College London demonstrated that mobile phone text reminders can improve adherence to medications (Wark and Car 2015). Overall, implementation of such technologies has high user satisfaction and costs are generally very low, thus this can be an efficient and effective tool. The study noted though that the mobile phone reminders should be individually tailored and constructed according to behavioral health theories tested by randomly controlled trials.

In addition to healthcare adherence, technology has also been shown to have positive effects on health outcomes. A study conducted at the Medical University of South Carolina found that interpersonal psychotherapy can be implemented over the telephone to effectively alleviate symptoms of postpartum depression (Guille and Douglas 2017). Furthermore, a study conducted at Syracuse Medical Center found that telephone based collaborative care can help manage and control moods and stress levels in patients with anxiety and panic disorders (Shephardson 2018).

Technology has also been found to positively influence nursing knowledge and practice. For example, a study at Western University found that Twitter might be a helpful asset in nursing education because it offers students an interactive and dynamic learning experience (Booth and O'Connor 2017). More research is needed to determine the long term learning outcomes of using social media to facilitate education. Furthermore, a study conducted by Borglin and Bohman

(2015) found that online learning modules could be an effective tool for nurses to conduct pain assessments and patient reported pain.

Technology has been quite an asset to the healthcare field within the realm of communication. Studies show that the implementation of technology to facilitate communication between patients and physicians was found to be advantageous for the use of follow up care for patients living at home (Lindberg *et al.* 2013). In addition, technology provides increased accessibility and can be cost saving for patients. It is important to note that while the benefits of technology in healthcare are many, there is no replacement for a face-to-face meeting between a physician and patient but can serve as a complement.

A study conducted at the University of Nebraska Medical Center analyzed 104 patients with cardiovascular disease in the following three age groups: young adults (ages 19 - 39 years), middle aged (ages 40 - 64 years), and senior citizens (ages 65 years and older) (Clarke *et al.* 2020). The study looked at the preferences of the three age groups regarding communication. Qualitative analysis of the data collected demonstrated that while young adults and middle aged adults favored text messaging, phone calls, or emails, senior citizens preferred direct interaction with healthcare workers to communicate healthcare information and plans. These findings concur with the fact that not all senior citizens own internet connected devices or have the necessary skills to properly use them.

Fortunately, studies are beginning to demonstrate the narrowing of the technology gap between senior citizens and the rest of the population (Clarke *et al.* 2020). A study conducted at the Pew Research Center in Washington, D.C. found that between the years 2000 and 2015, senior citizens had the highest rate of change and increased proficiency in using the internet. Additionally, a 2016 study by Gordon and Hornbrook found that 75 percent of senior citizens

now have access to a laptop, and 25 percent of them even own a tablet. However, while senior citizens are beginning to implement more technology into their lives, studies show that senior citizens still prefer technology that has been around longer and with which they are more familiar. Additionally, senior citizens do prefer phone calls over texts or emails when dealing with their healthcare due to the benefit of the human interaction involved. These results show the importance of using a combination of older and newer technology in order to satisfy all age groups who utilize the healthcare system.

A newer and now prominent area of technology in healthcare communication is the emergence of Telemedicine as an alternative to in-person patient visits. Telemedicine has been shown to increase access and decrease costs of medical care (Hare *et al.* 2020). Until recently, Telemedicine has not been commonly adopted by most physicians in the United States. However, due to the coronavirus pandemic, the healthcare system has moved towards more technology to allow people to receive care without having to leave their homes. Thus, Telemedicine has become an increasingly popular option that combines convenience with quality care. In general, one would assume that the quality and standard of care over Telemedicine could not compare to that of an in-person visit. However, this is not always the case. In fact, studies have shown that Telemedicine could provide the same standard of care as an in-person visit for an asthma evaluation (Hare *et al.* 2020). Additionally, Telemedicine is becoming so important that the Accreditation Council for General Medical Education (ACGME) and Liaison Committee on Medical Education have recommended that Telemedicine be included within medical student and resident trainings.

Decision Making and Doctor-Patient Roles

The process by which medical decisions are made has drastically changed over the last century. Medical decision making had previously assumed that the doctor provided the best healthcare for patients even without consulting them. In 1972, Dr. Robert M. Veatch, in *Models for Ethical Medicine in a Revolutionary Age*, proposed that the “sharing of decision making” between the doctor and the patient could be a more effective mode of communication for optimal patient care. Veatch argued that a doctor is constantly making choices regarding what is “significant” and what is “valuable” for a given patient. Thus, personal preferences will always be inherent in the healthcare decision making process. Thus, it is imperative to determine how those decisions should be made to provide effective healthcare for each patient. In his article, Veatch described various models for the patient-physician relationship, among them the engineering model, the priestly model, the collegial model, and the contractual model.

The engineering model involved the physician presenting the facts to the patient, without input of personal opinions. Veatch noted that this was due to unconscious biases; this model can be virtually impossible to achieve. Even if this approach was possible, Veatch argued that this model could trigger ethical concerns. He compared caring for a patient without asking any questions to a “plumber making repairs,” fixing different parts of the patient’s body as if they were an object. Veatch considers this to be “morally outrageous” because doing so dehumanizes the patient. He gave an example of a doctor who believed abortion was murder and, thus, was morally unable to perform an abortion, even if the patient did not consider it as murder. Veatch concluded that the engineering model put the physician in a morally compromising position.

The priestly model is when the patient gives the physician complete autonomy over medical care. Veatch argued that patients, who are not involved at all in the clinical decision

making process, end up transferring the physician's expertise in science to expertise in moral advice. This interaction made the physician into a version of a religious leader, in addition to being a medical doctor. For example, consider a doctor advising a pregnant woman who had taken thalidomide that the odds of having a healthy baby were minimal. "Speaking as a physician," that is a health risk she should not take, as the doctor is abusing his power as a physician, and advising beyond his scope of qualification. Veatch concluded that the priestly model positions the physician as the moral authority which forces the patient to compromise on individual freedom and dignity.

In the collegial model, the physician and patient see themselves as colleagues with a common goal of preserving the health of the patient. Veatch admitted that in an ideal world where the patient and physician have mutual respect for one another, this would be the best approach. Unfortunately, the differences between physicians and patients, be it race, socioeconomic level, or value differences, make it difficult to assume that this model was practical.

This brought Veatch to the final model, the contractual model which involves the physician and patient entering into a contractual relationship, where both parties have obligations and responsibilities towards the other. The contractual model allowed for the sharing of ethical and moral responsibility between the patient and physician. The patient maintained freedom of control over significant choices that impacted upon his healthcare, while the day-to-day decisions were made by the physician. Neither the physician nor the patient act in a way that would be in opposition to their moral standards, or else the "contract" is broken. This model was an early example of shared decision making, which has since emerged as the ideal for a patient physician relationship.

Since the model of shared decision making was first proposed, it has been widely studied and analyzed. One such study, conducted at Fox Chase Cancer Center in Philadelphia, involved primary care patients filling out a questionnaire about their satisfaction of care and their attitudes towards their illnesses after visits with their physicians (Lerman *et al.* 1990). The intent of the study was to elucidate patients' perceptions of physician-patient interactions and to evaluate the relationship of those perceptions to pertinent beliefs and attitudes towards illnesses. The researchers found that patients' perceptions regarding their physicians' efforts to encourage and facilitate shared decision making was correlated to a higher level of understanding, control, reassurance, expected functional improvement, and overall satisfaction with their physicians. Furthermore, patients who indicated that they were more involved in decision making were more satisfied with their physicians' technical competence, Patients who expressed their opinions were more satisfied with their appointment visit with the physician.

Smith *et al.* (2011).evaluated the cognitive and emotional aspects between 20 oncologists and 55 early breast cancer patients.. Their study consisted of audio-recorded visits with pre-consultation surveys and then follow-up mailed surveys at 2 weeks and 4 months post-consultation. The data showed that shared decision-making was positively associated with satisfaction with the decision even after four months. It is important to note that emotions can also play a key role in the decision making process.

Patients' perceptions about their involvement in healthcare appeared to be related to their illnesses, as well as to their recovery. Kashaf and McGill (2015) analyzed the relationship between shared decision making in cancer treatment and increased quality of life outcomes. They found suggestive evidence of a positive correlation between the user of shared decision making and increased quality of life in cancer patients. Brody *et al.* (1989).found that “active” patients

reported less discomfort, greater alleviation of symptoms, and more improvement in their general medical condition one week after visiting their physicians than did “passive” patients.

Furthermore, “active” patients were found to have a greater sense of control over their illness and less concern with their illness one day after visiting their physicians than their “passive” patients.

Adherence to medication is another benefit of shared decision making. Schoenthaler *et al.* (2012) analyzed the various factors that influence medication adherence in 608 patients with type 2 diabetes. The researchers found that shared decision making was associated with medication adherence. However, the researchers also found that the relationship between shared decision making and medication adherence was more correlated as the patient’s level of social support increased.

Shared decision making requires that patients understand their options and associated risks, benefits, and uncertainties. A study by Pieterse and Finset (2019) analyzed the further implications of the shared decision making model, noting that it was not one size fits all. An individual’s numeracy and ability to read, understand, and gather information was positively associated with the perception of physicians' effort to achieve shared decision making. The researchers also found that the harder it was for patients to ask questions to their physicians, the lower their socioeconomic status and the harder it was for them to achieve a shared decision with their physicians. A study conducted at the Feinstein Institute for Medical Research interviewed 24 patients with cystic fibrosis and their families to assess their information needs and preferences regarding receiving a lung transplant (Basile *et al.* 2019). The study indicated a high degree of diversity in the type, manner, and depth of information that was communicated. For example, some patients believed that more information about prognosis would allow them to make the most informed decisions, while others found this information frightening. Additionally,

some patients found it imperative to hear from other patients who had experienced the procedure, in addition to hearing from the physicians. Other patients had no desire to hear about the experiences of other patient experiences to make their decisions. This study indicated the need for flexibility and open mindedness when implementing shared decision making. It was also important to note that preferences may not always be the best guide for deciding how to implement shared decision making. Some information may be difficult but necessary for patients to make decisions, even if they outwardly express aversion to hearing such details. In these types of situations it was important to consider that it may be unethical to listen to a patient's preference for limiting access to information that would aid in making more informed decisions.

Another factor that can influence the ability for physicians and patients to achieve a shared decision making relationship is time. Herrmann *et al.* (2019) looked at how limited time with the doctor influenced the ability for a shared decision making model to be implemented. After surveying 400 out-patients, the researchers found that those patients who reported not having sufficient time to consider their options when making important decisions related to their healthcare plans had significantly higher odds of experiencing discordance in their decision, as compared to those patients who reported to have sufficient time to consider their options. The study concluded that "patients should receive adequate time when making cancer treatment decisions. This may help patients "digest" and use the information they received, and become involved in decision making, to the extent they desire."

Gender also played a role in the effectiveness of the implementation of shared decision making. A study performed at Johns Hopkins University School of Hygiene and Public Health analyzed the literature describing communication differences between physicians of different gender. Female physicians showed a great affinity for collaborative models of a patient-physician

relationship as compared to male physicians (Roter and Hall 1998). Female physicians spent more time with their patients and were more likely to engage their patients in discussion of their social and psychological context, both of which impacted upon their decision making, and dealt more often with feelings and emotions. Additionally, female physicians facilitated patient participation in discussion of healthcare plans more effectively than did male physicians. This study suggested that male physicians should actively push themselves to implement these skills that women physicians used to facilitate shared decision making with their patients. This would level the playing field of shared decision making accessibility between male and female physicians.

Unfortunately, shared decision making is not yet the norm in most healthcare facilities. An observational study conducted by Berger *et al.* (2017) analyzed how shared decision making was implemented among 18 hospitalized patients and 9 physicians. After surveying both the physicians and the patients, all physicians reported that they had explained their plan of care to the patients and that their patients had understood the plan. However, after asking the patients, the researchers found that many patients did not in fact understand their assigned plans of healthcare. Additionally, physicians rarely asked patients for their opinions about healthcare plans and no decisions were made with the patient. Furthermore, some patients disagreed with the healthcare plans assigned to them by physicians, but often this resulted in conflict. One potential reason was that some physicians believed that sharing control of decision making with patients would lower their esteem as a medical provider (Lerman *et al.* 1990), even though other studies showed that discussing treatment options led to more trust and belief of competence of the physicians by their patients.

Child Life Specialists

Child life specialists play a key role in communicating complicated and intense situations to children. These specialists work with infants, children, adolescents, and young adults to promote coping skills and minimize the adverse effects of hospitalization, of healthcare, and of potentially other stressful situations impacting on their development and well being (Committee on Hospital Care and Child Life Council 2014). Additionally, child life specialists work to educate patients and their families about health conditions and prepare them for medical procedures. Regarding such intense experiences, child life specialists work to help children process impending or previous situations. Child life specialists utilize therapeutic play and expressive modalities to accomplish their goals. Establishing a therapeutic relationship with patients and their families gives families the support they need throughout the hospitalization process.

Another way that child life specialists contribute to the healthcare team is by providing distractions for children during the actual procedures. Distraction is one non-pharmacological strategy found to be effective in providing comfort and decreased experiences of pain for children and their families during procedures. A study conducted by the Nepean Blue Mountains Local Health District in Australia analyzed the perceptions held by nurses regarding child life specialists and found that child life specialists were extremely helpful in creating a feeling of ease for children during procedures (Drayton *et al.* 2019). However, nurses often struggle with implementing effective distractions due to various workplace restraints, such as focusing on the task, time, and assisting the physician during the procedure. The nurses contrasted their roles with those of child life specialists. Nurses viewed themselves as mean and unkind due to the nature of their work, whereas child life specialists were seen as positive for children and

families. In fact, the nurses pointed out that many children viewed wearing scrubs as a trigger that something painful was about to happen. Child life specialists do not wear scrubs so this trigger is not associated with them. This contrast made it easier for child life specialists to distract the children during the hospital procedure.

The above-noted study also showed that child life specialists can be beneficial prior to the performance of the medical procedures, because they can spend time with the patient and family during this time of high stress and anxiety. Supporting parents before a procedure can significantly reduce anxiety for their child (Hilliard and O'Neill 2010). A nurse, however, generally does not have the time to spend with the patients and their families prior to the medical procedure. Child life specialists have the opportunity to make a major positive impact on the hospital experience both of the child patient and on the family.

Communicating Bad News

It is important that bad news be delivered to patients in an effective and productive way. When bad news is delivered poorly, patients suffer and carry these moments with them throughout their illness. In fact, a patient's perception of the information received correlates with future anxiety and depression due to the disease (Tulsky 1998). The level of severity of a patient's unresolved concerns also have correlated with disease-related anxiety and depressive disorders. These mental health issues may elicit from the manner in which the doctor conveys bad news to the patient.

It is important for physicians and healthcare workers to understand that they cannot change the fact that bad news will create an impact on their patients. However, it is still extremely important that physicians learn to convey such sensitive information with empathy,

expertise, and clarity. Failure of physicians to effectively communicate with patients in these types of situations can lead to unnecessary anxiety and fear. However, it may be unclear exactly how to communicate when the information conveyed is life altering bad news.

In 1988, the Cancer Research Campaign Psychological Medicine Group in Manchester, led by Maguire and Faulkner published guidelines addressing this issue. The setting is extremely important when communicating bad news. It is widely accepted among experts that bad news should be delivered face-to-face and in a private, quiet location. The patient's support network should be identified, involved, and present, if desired. Additionally, in advance of a meeting, the physician should determine the patient's current knowledge about the situation so that he does not accidentally mention something life altering under the assumption that the patient was already aware of the information.

Maguire and Faulkner emphasized that the goal of the physician was not to protect the patient from the bad news because this will skew the patient's perception of the reality of the situation, which can develop to unsound decisions to protect the patient from bad news. The goal, instead, should be to gradually oversee the patient's transition from believing there is no health issue to understanding the severity of living with a life altering disease. Communicating new bads too abruptly can provoke denial because the information is too painful to process. Thus, it was not suggested that a physician come right out and inform a patient of, for example, cancer. Instead, the healthcare provider should first communicate to the patient that the news is not so positive, such as by saying, "I'm afraid it looks more serious than an ulcer." Even at this point, many physicians are tempted to further soften the blow by saying something along the lines of, "Even so, we should be able to do something about it." However, this may be incorrect,

as the physician should resist this urge and allow the warming sink in and to monitor the reaction of the patient.

The next stage depends on the patient's response. The patient may respond with a statement like, "That's all right, doctor, I'll leave it up to you," which is indicative that, at this time, the patient did not want to know more of the illness. On the other hand, if the patient responded with a question like, "What do you mean it's not an ulcer?," this would suggest that the patient wanted more information. In this type of situation, it is still very important for the doctor to not come out directly and say, "Mr. Smith, you have cancer," because this would be too harsh a statement. Instead, the physician should employ euphemisms, such as "a few odd cells," "a kind of tumor," "a bit cancerous," *etcetera*, to allow the patient to slowly process the unpleasant information.

Throughout this interactive process, it is imperative for the physician to constantly communicate with the patient about his/her health, both physical and mental. The more the physician understands the specific concerns of the patient, the more effectively the physician can begin to address the patient's immediate concerns and return the patient's sense of self determination to succeed. The physician must be mindful to exude a positive demeanor and to transmit hopefulness, but still to be realistic of the health concern.

Another situation that doctors and healthcare professionals must learn to maneuver involved answering difficult questions, such as "Is it cancer?" or "I'm going to get better, aren't I?" In these situations the healthcare professional must understand why the question was asked. Perhaps, the patient wanted to deny the severity of the situation and was looking to the healthcare professional to provide a false sense of hope. Yet, it is important for the healthcare provider to be realistic with the patient. Conversely, there is also no reason to enumerate every

health risk and potential difficulty that may arise during treatment of the illness. Another aspect is that the patient might want to confirm any suspicions of a prognosis. In this case, the best approach is for the physician to be clear and direct about the situation. To comprehend why the patient was asking emotionally difficult questions, it can be useful for the healthcare professional to state, “I would be happy to answer your question, but can I first ask why you're asking that?” Along the way, it is imperative that physicians allow for emotional expressions and to provide empathetic responses, to encourage questions, and to develop a followup plan with the patient.

Maguire and Faulkner (1988) stress the importance of constructing communication tactics around the way the patient reacts and the questions that patient asks along the way. In the end, there cannot be any unilateral decisions made about these topics that would apply to every situation. The aforementioned advice should not be implemented unquestionably but rather used as guidance in order to effectively communicate difficult information to patients.

Educating Physicians to Communicate Bad News

Unfortunately, many physicians are not properly equipped with the aforementioned skills of delivering bad news to patients. A study conducted by Spafford *et al.* (2009) found that formal classroom training was not sufficient to be an effective communicator of bad news. Practice and role playing exercises were necessary for physicians to develop proper skills in effective communication of negative prognosis to patients.

In 1998, Dr. James Tulsky from the Center for Health Services Research in Primary Care published an article outlining effective ways to teach these skills to physicians and healthcare professionals. In planning curriculum to teach the delivery of bad news, educators must be informed about the barriers that impede good performance and understand what compromises

optimal execution of the skill. The first barrier to achieving this skill is that healthcare workers have little or no training and therefore poor skills and unapprised fears. Such fears include self blame for failing the patient, inadequacy in the face of an unleashed emotional outburst, displaying one's emotion, and confronting one's own fears of serious illness or death. Such barriers are cognitive and emotional, thus education programs must focus on teaching knowledge and skills. as well as to facilitate the development of a strong emotional intellect and control.

Research suggests that the ability of a physician to deliver bad news can be improved if certain elements are in the curriculum (Tulsky 1998). Such elements include the opportunity to practice skills, to receive feedback on those skills, and to have training on the learners' affective experience related to delivering bad news. Physicians must learn to empathize with their patents by acknowledging their own feeling of inadequacy, defeat, and fear.

In his guidelines, Tulksy outlined some of the key components of the curriculum that educators should be aware of when training physicians and healthcare workers to deliver bad news. Tulsky acknowledged that each institution will likely have to tailor its curriculum to the available resources, however he strongly recommended implementation of the following general components.

The first component of the curriculum should include small groups. Although some teaching tools, such as videos demonstrating examples of physicians delivering bad news, can be used in large groups, practicing such skills and effecting change requires interaction with small groups. Communication skills and behaviors cannot be taught in a large lecture hall. Small groups allow all the learners to participate in roleplay and feedback. Tulksy recommended groups of four learners plus a facilitator were most effective. The facilitator's role was to help the

learners notice and respond to their own shortcomings, rather than to only propagate standardized information.

The second component of Tulsky's curriculum involved demonstration and role modeling. Demonstration can be an effective tool to focus the group and to relieve performance anxiety. The facilitator can model between poorly delivered bad news and well delivered bad news, and the learners can watch and point out the shortcomings in the poorly delivered news as well as to comment on the positive aspects of the well delivered bad news. Ideally, the poorly delivered model and the well delivered model should demonstrate similar situations in order to emphasize the differences between the two. Another option, instead of a demonstration, can be the showing of a video of a physician delivering bad news. Today such videos can easily be found for free on the internet and this form of demonstration is often more convenient, while still proving to be effective.

A key element of Tulsky's curriculum is role play. The only way to learn communication skills is through practice. Role play allows learners to practice strategies, make mistakes, and receive feedback without harming patients. Successful role plays involve creating an environment in which learners feel safe, understand their task, and have the opportunity to receive supportive, specific, and constructive feedback from their peers and from the facilitator. Tulsky suggested allowing learners to call for a "timeout" at any time or to ask other participants for help, if needed. After completing the role playing, it is usually best for the learner who played the physician to comment on his performance on what could be improved. This would be followed by the learner, playing the role of the patient, and thereafter by the other learners. It is also extremely effective if learners, once they have received feedback from their peers, are given the opportunity to replay their roles and to implement new ideas.

For learners to effectively gain from role play exercises, it is important for the learners to take the exercise seriously and treat it as if they were really delivering bad news to a patient. One way to accomplish this is by constructing situations that are relevant to the learner's work setting. For example, a facilitator leading a group of oncologists in a role playing exercise can focus the role play on informing a patient of cancer while a facilitator leading a group of primary care doctors can focus on informing a patient of a positive HIV test. While scripted roles can be useful to practice specific skills, one is likely to achieve the greatest benefit by providing the learners with the opportunity to offer situations from their own experiences.

The final element that Tulsy suggested is to implement exercises that combine skill and affective training. Teaching skills must be combined with helping learning develop self awareness and empathy for patients in order for them to be able to deliver bad news with compassion. Many teachers advocated for dedicated "personal awareness" sessions to heighten these abilities. Such exercises could include the "learner-loss pair" technique where learners are paired in groups of two and are told to share a loss or hardship with their partner. The partner is instructed to listen actively and is not to speak to interrupt. After about ten minutes, the partners switch roles and the listener now becomes the one to share a loss or hardship with the partner. After another ten minutes, the group reassembles and discusses their observations. Another technique to develop empathy is to bring into a session a real patient who is struggling with a serious illness. The group can interview the patient about his experiences experiencing the hardship, the way in which the news of the illness was delivered, the emotional impact that the illness has had on him and his family, and other elements that the patient was comfortable disclosing to give the learners a real sense of what it was like to have a serious illness.

My Experience Volunteering at the Department of Pediatric Hematology and Oncology

In the summer of 2019, I volunteered in the Department of Pediatric Hematology and Oncology at Cohen's Children's Hospital in Queens, New York. The Department consisted of a wide array of cancer-related programs and centers. Some of the programs included a bone marrow failure program, a pediatric vascular abnormalities program, a childhood brain and spinal cord tumor center, comprehensive hemoglobinopathy programs, pediatric leukemia and lymphoma programs, rare tumors and sarcoma programs, and a stem cell transplantation program. In addition to participating in morning rounds and visiting patients throughout the day, I also had the privilege of attending Department meetings including tumor boards where the Department collaborates to discuss difficult tumor cases that arose in the Department. During that summer, I was exposed to countless examples where difficult decisions had to be made about what information to communicate to patients, and how to best communicate this information.

One such difficult situation involved a 14 year old patient with graft's vs. host disease, a condition where donated stem cells or bone marrow (the graft) view the healthy tissues in the patient's body (the host) as foreign and attack them. The patient had a bone marrow transplant not long before I started volunteering but unfortunately his body did not accept the transplant and instead was rejecting it, resulting in a massive infection. One day during morning rounds he asked the doctor, "Am I going to die?" I was shocked and sad to hear that such a young boy felt the need to ask such a tragic question. I was anxious for the doctor to answer.

I knew based on meeting with the residents and attending physicians that there was not much to do for the boy at this point, the doctors were completely at a loss of his cure. The infection had spread through his body at this point, and his initial problem of having defective

bone marrow had not been solved. While the issue of the bone marrow continued to worsen, the doctors also made note that a life saving surgery might kill him due to his infections. For now his situation was stable, but the doctors knew it was only a matter of time until it would worsen. The situation was so unpredictable, that the doctors could not guarantee anything about the patient's future. However, they also did not know for sure that he would die, or when that would happen. Therefore, the doctor answered a simple "no" and reassured the patient that if he was imminently dying, they would let him know.

I remember being fascinated and saddened by this encounter, but also extremely impressed with the doctor. The doctor's confidence clearly made the patient feel better while still being realistic about the fact that he could die. This type of honesty was clearly what the patient needed, but was scared he would not be told that he was dying due to his age. The doctor was perceptive to the patient's concerns and responded accordingly.

Another example of the importance of tactful doctor-patient communication came up during tumor board which is where various doctors from the department came together to discuss how to help patients with abnormally difficult tumors. While some doctors advocated to begin treating the patient even though the situation seemed dire, others advocated not treating the patient because by doing so they would be giving the patient a false hope that his situation was treatable. In fact, according to all the experts it looked like the patient was going to die no matter what the treatment was. In the end, the doctors decided to communicate to the patient that they did not believe treatment would help, but if the patient wanted to proceed, they would agree and perform the procedure.

In the end the patient decided to go through treatment anyway, and I never heard what happened to him. However, I found it extremely inspirational that the doctors maintained such

high moral standards among themselves and took the issue of giving false hope very seriously. At the end of the meeting, the doctors concluded that in the end all they could do for sure was to be completely honest with the patient about the situation, and be there for the patient and his family.

Contrasting these two experiences demonstrated that there is not a one-size-fits-all approach for communicating bad news to patients. There needs to be a balance between being completely transparent with patients, but at the same time sensitive to the needs of the specific patient. Doctors also need humility when deciding what to communicate because in situations where the medical outcome was questionable, it would be inappropriate for the doctors to convey to the patient their best guess as a fact. The issue discussed at tumor board demonstrated that doctors must be honest with their patients for patients to be able to make informed decisions. However, the situation of the patient with graft vs. host disease taught me that doctors must be sensitive about what information to convey, especially when the doctors can only guess and do not understand a medical situation in its entirety.

Concluding Remarks

One of the key elements in facilitating an optimal patient experience and care involves maximizing effective communication between the physician and the patient. Unfortunately, there are significant barriers that make it difficult for effective communication to be achieved such as language barriers, socioeconomic differences, and differences in culture and ethnicity to name a few. It is imperative that physicians are aware of such barriers and make an effort to ensure that all patients receive the highest level of care regardless of the potential barriers involved. In general, physicians must ensure that they communicate with compassion and honesty. This is

especially significant for physicians delivering bad news, and for such situations it is imperative that physicians are trained on how to properly communicate difficult topics with their patients. Failure to do so could end up causing the patient extra and unnecessary pain. Doctors must be mindful that the manner in which they communicate with their patients has a significant impact on the patient care experience as a whole.

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