Communication in Acute Ambulatory Care

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Abstract

Effective communication has been linked to better health outcomes, higher patient satisfaction, and treatment adherence. Communication in ambulatory care contexts is even more crucial, as providers typically do not know patients' medical histories or have established relationships, conversations are time constrained, interruptions are frequent, and the seriousness of patients' medical conditions may create additional tension during interactions. Yet, health communication often unduly emphasizes information exchange—the transmission and receipt of messages leading to a mutual understanding of a patient's condition, needs, and treatments. This approach does not take into account the importance of rapport building and contextual issues, and may ultimately limit the amount of information exchanged.

The authors share the perspective of communication scientists to enrich the current approach to medical communication in ambulatory health care contexts, broadening the understanding of medical communication beyond information exchange to a more holistic, multilayered viewpoint, which includes rapport and contextual issues. The authors propose a socio-ecological model for understanding communication in acute ambulatory care. This model recognizes the relationship of individuals to their environment and emphasizes the importance of individual and contextual factors that influence patient–provider interactions. Its key elements include message exchange and individual, organizational, societal, and cultural factors. Using this model, and following the authors' recommendations, providers and medical educators can treat communication as a holistic process shaped by multiple layers. This is a step toward being able to negotiate conflicting demands, resolve tensions, and create encounters that lead to positive health outcomes.

Communication competencies have been increasingly used as an organizing principle for medical education, starting in graduate medical education[1–3] and diffusing into other parts of the education continuum. Thus, communication skills are becoming more essential to medical education.[4] Interpersonal and communication skills include the following six essential elements of patient–provider communication that were formulated in the Kalamazoo consensus statement, as reported by Makoul[1] in 2001: Open the discussion, gather information, understand the patient's perspective, share information, reach agreement on problems and plans, and provide closure.

These elements emphasize effective information exchange, which is a necessary but not sufficient element of effective patient–provider communication.[5,6] Recently, the patient-centered medical home model of communication has broadened communication expectations to include the values and experience of the patient, such as understanding the whole person, finding common ground, incorporating prevention, enhancing the patient–provider relationship, and being realistic.[5,6] These elements emphasize persuasion, balancing needs, and relationship building beyond simple information exchange and have been shown to be associated with effective health outcomes.[7,8] Although a valuable addition to previous ways of seeking meaningful patient–provider encounters, the patient-centered medical home model does not provide a mechanism for achieving its aspirations beyond increasing awareness.

An alternative to an information exchange approach is the use of a multilayered, holistic perspective[9] that emphasizes the contextual elements that shape the medical encounter. These contextual elements are important in all medical encounters, including those in the acute ambulatory care setting, where there are significant challenges and constraints to effective communication.[10–12]

Recently, we have fostered a close working relationship between medical and communication scientists at the Department of Communication and Journalism and the School of Medicine at the University of New Mexico. Communication scientists are scholars from a variety of disciplines who use either quantitative or qualitative methods to investigate and understand the way that verbal and nonverbal messages are shared to create meaning for the participants. In this article, we share observations we have made from our involvement in that collaboration. We believe these observations can enlarge upon the previously described elements of patient–provider communication and suggest ways for future study and improvements in medical education. We focus on the acute care ambulatory setting because it presents unique challenges due to the acuity of a medical illness presentation, the time constraints, and the lack of a previous patient–provider relationship.

Specifically, we wrote this article to share the perspective of communication scientists to broaden the understanding

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of communication in medical encounters beyond information exchange to a more holistic, multilayered viewpoint, which includes rapport- and relationship building and contextual issues. In particular, we attempt to explain why the information-exchange-focused model of communication may not meet the patient's and provider's goals for high-quality care and how a holistic, multilayered model could improve the quality of communication. We present our thoughts below in the following sections: the importance of communication in medical encounters, the context of acute ambulatory care, a socio-ecological model of communication for acute ambulatory care, and recommendations for improving acute ambulatory care communication.

The Importance of Communication

Certainly, the inclusion of interpersonal and communication skills by the Accreditation Council for Graduate Medical Education (ACGME) as a core competency for all residents signifies the importance of communication for medical encounters. This competency indicates that "residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals."[3]

Effective communication is essential within patient–provider relationships, as it has implications for quality of care[8] and leads to better health outcomes among patients.[5] Better health outcomes include emotional health, physiological health, and functional health, such as pain control and symptom resolution.[13] Effective communication also heightens patient compliance to treatment, medical decisions, and outcomes.[14] On the other hand, ineffective communication is associated with malpractice claims, lawsuits, and medical errors.[15] In fact, the leading causes of errors resulting in patient harm are often communication failures.[16,17]

The importance of effective information exchange and collaboration cannot be overstated in acute ambulatory care.[10,12] Communication scientists emphasize the importance of high-quality information but recognize that information exchange is only *one* element of communication—I share information with you, and you take it and hopefully understand it and comply. If the information was not understood, it may be a problem with how I shared the information. If the information was understood and not complied with, that is likely your fault. But what happens when multiple messages are exchanged? When do they provide clarity, and when do they create confusion? There is little emphasis on how multiple messages are exchanged in order to negotiate and create meaning and, more important, how multiple messages are understood. Further, there is little emphasis on the larger contexts that shape the patient–provider encounter.

Moreover, communication scientists emphasize that our lives (including relationships, health, and work) are socially constructed.[18,19] In other words, individuals construct their social world through communication, which in turn affects the meaning they associate with their experiences.[20,21] Additionally, communication is contextual.[22] A message cannot be taken out of the context of the particular event, environment, or social relations that exist for the people involved. A discussion about end-of-life care is very different when a patient is on a ventilator surrounded by family than when the patient is sitting calmly in an examination room. Thus, communication scientists emphasize a holistic approach toward any particular communicative situation.

Before we introduce the socio-ecological model of communication that integrates this holistic perspective, we first discuss the context of acute ambulatory care.

The Context of Acute Ambulatory Care

Ambulatory care is medical care delivered as an outpatient service. Ambulatory care sites include primary care centers, office and outpatient surgery centers, hospital emergency departments (EDs), dialysis clinics, chemo and radiation therapy clinics, diagnostic imaging centers, and occupational and health centers.[23] In this article, we focus on acute ambulatory care, which involves EDs, urgent care centers, acute care physician offices, and walk-in clinics. These are settings where patients typically seek care for a new or worsened symptom requiring medical attention where timeliness of care is a high priority. There are several contextual characteristics about acute ambulatory care that inhibit effective communication.

First, acute ambulatory care is offered at multiple locations and thus involves numerous handoffs or transitions of care. Depending on the health condition, patients may be sent from urgent care to emergency care, emergency care to surgery, or primary care to a medical specialty such as oncology or cardiology. For example, a patient with asthma and difficulty breathing could initially seek care at a doctor's office, receive a breathing treatment, be sent by an ambulance to an ED, receive more treatment in the ED, and then be sent for follow-up to a pulmonary specialist the next day. The patient would encounter nurses, paramedics, and several types of physicians in a variety of settings, and the resulting different states of discomfort and privacy would likely affect communication with the patient's providers. Furthermore, complexity is caused by scheduling, travel, and insurance as well as by coordinating care with other providers and sites.[23]

Second, information exchange can be challenging for acute care ambulatory physicians, as many treat patients on the basis of their first encounter without knowing the patient's medical history or having established a relationship.[24]

Third, conversations are often constructed in a time-constrained manner.[25] For instance, Schwartz et al[26] found that the average ambulatory care visit lasted only 19.3 minutes. Thus, acute conditions mean that quick decisions and actions are needed, and thus effective communication can be constrained.[27]

Fourth, because of the nature of ambulatory care, interruptions are frequent and thus disrupt communication.[27] Each interruption slows patient care and can cause medical mistakes.

Finally, the acuity of the problems, which may evolve rapidly into life- or limb-threatening events and often have uncertain causes, may add additional strain and tension to the encounter.

To further illustrate these communication challenges and constraints, several studies by communication scientists about communication in the ED reveal communication challenges that cannot be met by simple improvement in information exchange or transfer.[10,11,28,29] For example, Eisenberg et al[11] argued that thinking about the ED as a communication environment focuses on how the ED is socially constructed and maintained by and through interaction processes. The authors argue that the type of communication environment in the ED reinforces (and potentially changes) work practices and the culture of the ED. They also explain that "an exclusive focus on information transfer leaves out much of what is most important (and most challenging) about health communication practice."[11] In addition, Dean and Oetzel[10] found that ED physicians recognized the importance of effective communication and defined it in a way that is consistent with ACGME competencies, but struggled with performing a holistic communicative approach. The authors' interviews with 17 ED physicians, and 70 hours of observations in the ED, revealed five main dimensions of effective communication in the ED: communicating in an efficient manner, communicating in a clear and accurate manner, communicating only relevant information, making sure that patients and physicians comprehend one another, and building rapport with patients. Ideally, all five of these dimensions are performed simultaneously to develop effective information exchange and collaboration. However, the ED physicians wrestled with three communication tensions related to these dimensions: being efficient versus building rapport, being efficient versus checking comprehension, and finding a balance between patients' and physicians' perspectives about clarity and relevance. For the first two tensions, in the vast majority of the times, physicians chose efficient communication, emphasizing the unique time constraints in the ED. Further, the physicians tended to emphasize their own perspectives of relevance and clarity rather than those of the patients.

A Socio-Ecological Model of Acute Ambulatory Care Communication

Most previous research (except investigations by communication scientists) surrounding ED and acute ambulatory communication focuses on information exchange,[11] and recommendations to improve ED communication have generally stressed information transfer rather than the larger context represented by a holistic, multilayered model of medical communication. A socio-ecological model recognizes the relationship of individuals with their environment and has been used in both health and intercultural communication contexts.[9,30] A socio-ecological model emphasizes both the importance of individual choices and also contextual factors as being layers of influence on the patient–provider interaction and, therefore, also on thinking about the structure and design of communication in a particular setting. Figure 1 displays the model developed by Street[9] that we adapted for the present article's context of ambulatory care. The model includes the following key elements: exchange of messages, individual factors, organizational factors, societal factors, and cultural factors. We briefly discuss each of these elements below. A thorough description of every component of this model is beyond the scope of this article, but more developed descriptions[9,30] can be consulted for further information.

Exchange of messages. Messages include the process of exchanging verbal (e.g., talk) and nonverbal (e.g., eye contact, vocalics, posture, gestures) elements. Drawing from work on communication competence in patient–provider communication,[31,32] messages involve two main categories—information exchange and relational communication. Information exchange includes seeking or gathering information, giving information, verifying information, checking for understanding, and reaching agreement on medical decisions and plans. Relational communication includes establishing rapport, opening discussion, demonstrating respect, displaying emotional support, and showing affirmation.[2,31–34] Connecting communication competence to the context of acute ambulatory care, information exchange can be viewed as a way to communicate in efficient, clear, accurate, and relevant ways, whereas relational communication can be seen as checking for understanding and building rapport with patients.[10]

Individual factors. The individual factors involve cognitive and affective elements and the communication styles and goals of the patient and provider.[9]

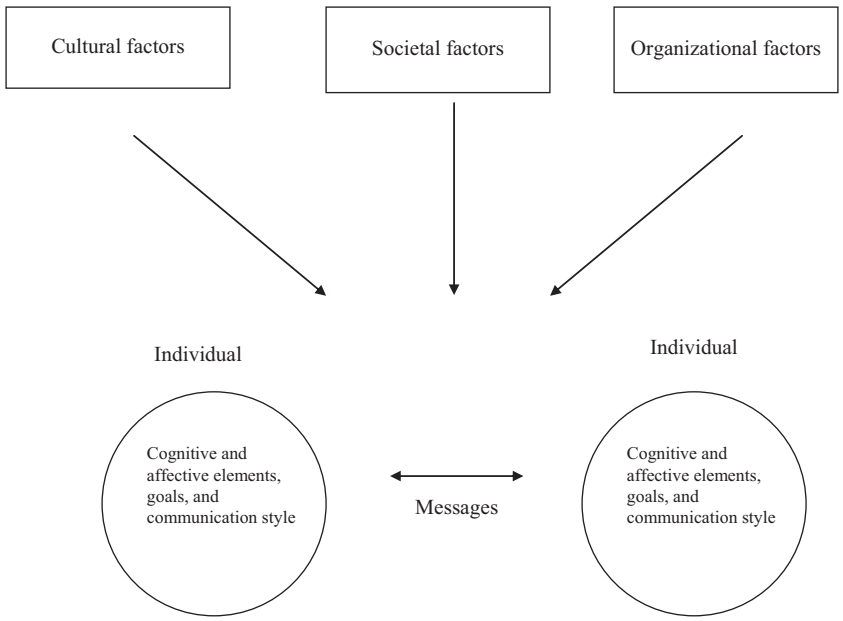

Figure 1 A socio-ecological model of acute ambulatory care communication. A socio-ecological model recognizes the relationship of individuals with their environment. The model emphasizes both the importance of individual choices and also contextual factors as being layers of influence on the patient–provider interaction and, therefore, also on thinking about the structure and design of communication in a particular setting. (Figure adapted with permission from a figure in Street RL. Communication in medical encounters: An ecological perspective. In: Thompson TL, Dorsey A, Miller KL, Parrott R, eds. Handbook of Health Communication. New York, NY: Routledge; 2003.)

The cognitive elements involve the perceptions that people have of the situation, including their medical literacy and their relationships to other persons, whereas affective elements include the emotions people feel during the encounters and also the ability to display and interpret emotions (usually through nonverbal cues).[8] Goals relate to the desired outcomes from an encounter. An obvious goal is being "cured" or having an ailment addressed (emphasizing information exchange), yet patients also have a desire to be respected and validated (outcomes of effective relational communication). Finally, patients and providers have typical patterns of interaction, or communication styles, that shape their ways of interacting and creating meaning in a situation.[9]

Organizational and societal factors. The organizational and societal factors include media, politics, and legal components. Organizational factors refer to the physical size and location of the health facility, the different types of services offered to clients, positive or negative working environments, and standards of care. Societal factors refer to the political–legal context such as malpractice litigation, patient bill of rights, and Medicaid/Medicare coverage.[9] For instance, the nature of the acute ambulatory context influences communication (e.g., time constraints), and yet that context is created through societal elements such as political and legal decisions as well as business elements (e.g., need to see numerous patients to stay financially viable).[35] Media also influence patient–provider interaction through various means, from advertisements encouraging patients to ask physicians about certain drugs, to popular television shows (e.g., *ER, Grey's Anatomy, House*), to access to health technologies such as the Internet; all of these factors influence expectations of medical encounters for patients.[36] Such factors should encourage providers to think about and design communication in the acute ambulatory care setting in a careful manner.

Cultural factors. Finally, communication can be challenging when people from different cultures meet in health contexts, as they have different ways of perceiving health and patient–provider relationships. Culture is often thought of as ethnicity or nationality, but it can also include religion, sexual orientation, and other factors that result in a group of people sharing (to varying degrees) similar values, beliefs, norms, perspectives, and a system of interpreting the world.[30] Culture is an important element in many dimensions, such as high- and low-context communication.[37] High-context communication focuses on the creation of meaning through indirect and ambiguous messages, which often rely on nonverbal communication, such as physical contact or eye contact, and the general context of the interaction. In contrast, low-context communication focuses on the creation of meaning through explicit and direct messages through verbal messages. Many providers focus on low-context communication because of the need for clear and efficient information.[10] Patients who use high-context communication tend to hint at issues, particularly when an issue might imply a disagreement or challenge to the provider, yet such hints may be misunderstood by providers who depend on low-context communication.

Recommendations

The socio-ecological model we have presented recognizes the process elements of communication as well as the complex contextual factors that shape communication in acute ambulatory care.[9,30] From this model and from the perspective of communication research presented in this article, we have the following recommendations for providers and medical educators in acute ambulatory care.

Recognize and resolve the tension between efficient information exchange and rapport building in acute care patient interaction. This can be done with a brief introduction by the provider to the patient about these twin goals at the outset of the encounter after introductions are made. For example, the provider can state the necessary goal of learning the patient's health issue while giving the patient the opportunity to share what he or she feels is important. Studies demonstrate that an either–or approach, where one goal is selected at the expense of the other, typically predominates.[10,11] However, studies also demonstrate that effective management of tensions uses creative approaches to redefine the tensions so that both goals (e.g., efficiency and rapport) are met.[38–40] This may involve a sequencing of the goals in tension so that first one and then the other goal can be met. Creative tension management in acute ambulatory care settings involves communication skills such as being attentive to nonverbal cues and displaying attention through nonverbal cues (e.g., by sitting down during the encounter)[12] and by using a "teachback" approach when providing instructions (e.g., asking patients to tell them what they understand are the next steps, to ensure the patient comprehends). In addition, motivational interviewing and narrative interviewing are approaches that emphasize understanding the patient's perspective by eliciting stories through open-ended questions and active listening that also can serve efficiency goals.[10,18,41] Of course, these approaches may not be relevant in acute situations involving massive trauma, but they represent an effective alternative to co-construct the encounter with the patient when the time and situation warrant.

Learn and practice effective communication in a complex and interruption-filled interprofessional environment that approximates the acute ambulatory setting. Current acute ambulatory care typically involves multiple care providers who can supplement and augment each other if properly prepared and trained. Effective communication will relate to the quality of teamwork, including cooperation and effective conflict management, among different types of providers and different specialties as well as to the communication skills of the individual providers.[42] High-quality interpersonal communication requires formal training in realistic environments, as such skills do not improve on their own.[43] There is some evidence that interprofessional communication and general communication skills used to manage tensions can be improved through multidisciplinary medical simulations.[42–45] Although simulations are commonly used in medical education, they tend to be unidisciplinary.[46,47] To address this potential deficiency, medical educators can partner with communication scientists and educators on their campuses to help the educators develop appropriate and realistic strategies for fostering the communication skills of ambulatory care providers.

Think about communication as design as an approach to address the complexity of communication in the acute ambulatory care setting. Thinking about communication as design[48,49] could be particularly helpful for ambulatory care administrators and medical directors. Communication as design involves developing a set of principles and contingency plans for how to communicate effectively in a particular setting, given the various constraints and challenges.[48] Communication as design might involve the use of technology or structures (e.g., systems) as guiding principles in a particular setting. Communication as design could include making changes to the elements of the environment to foster communication, such as altering the size and design of exam rooms in clinics or instituting noise policies for the ED. Rather than relying on a single person for the major communication responsibilities, it might be better to think about a network metaphor. The design aspect would be to think about the ways that patients' needs could be addressed by a network of people—everyone involved in giving care or supporting those who do so—rather than simply relying on the physician or nurse to fulfill communication needs.

Provide patients a better understanding about how the acute ambulatory care culture operates by giving them clearly written handouts. Posters or pamphlets that explain the normal processes and how and when patients should communicate their needs and what to do if their needs are not being met could supplement physicians' and nurses' communication. Doing so can help patients feel that the time they spent with the physician or other provider during an acute ambulatory care visit met or exceeded their expectations.[50]

Summing Up

In summary, providers must balance the needs for information exchange and relational communication in order to co-construct the patient–provider interaction. When providers engage in information exchange only, their needs become unduly central features of the communication, but when providers value and enact relational communication as well, they foster a partnership, leading to more holistic communication.[10] As such, it is important to note that providers must learn how to negotiate multiple communication goals in acute ambulatory care. First, providers must acknowledge the contextual implications of giving care in acute ambulatory settings. Second, they must be able to effectively identify when efficiency must take precedence, and thus focus more on information exchange, yet also be able to identify those situations where efficiency does not need to take precedence, where they can engage in more relational communication. In short, communication in acute ambulatory health care settings has to balance the dynamics of getting the job done and its relational aspects. Understanding this, and realizing that communication is a holistic process that is shaped by multiple layers, including rapport and contextual issues, is a step toward being able to negotiate conflicting demands, resolve tensions, and create encounters that leads to positive health outcomes.

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