Establishing good rapport in anesthesia-related doctor-patient communication: bridging the triangular communication between anesthesiologist-surgeon-patient

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As we know doctor-patient communication is central in clinical practice. Communication skill has been an essential component of clinical competence to become a five-star doctor. In the other hand, there are major problems in doctor-patient communication that would lead to medical disputes even malpractice suspicions. With effective communication, a definitive theory would turn into high-quality medical practice and improve patient safety and satisfaction to a whole new level.

Based on the Calgary-Cambridge observation guide, there is five point plan of tasks that embrace doctor and patient in daily interviews starting from initiating the session, gathering information, building the relationship, explanation, and planning, and closing. Those tasks would have been easily introduced when you are dealing with a good healthy patient. But in anesthesia-related, wide range of patients are met in different settings and conditions.¹

Anesthesiology is a highly skilled and professional specialist. Tensions and workloads are the usual burdens for doctors who are trained and occupied in anesthesiology. Because of their habitual response to stress and aggressive terms, communications seems to be small and unnecessary obstacle in order to get the patient treated.¹-²

It is common and undeniable that there is an internalized value in every anesthesiologist that still hold strong principles as the ‘second in command’ in every situation, behind surgeon in operating theater, and behind leading physician in the intensive care or in pain management. Shared responsibilities between several parties could be minimized unfortunately with minimal contact and communication. These things are commonly seen among anesthesiologists in many countries. Besides, communication skill lecture for doctors are not widely implemented, not even among anesthesiologists or residency in their training.¹³

Communication skill has to be learned in all level of medical personnel. It is not a gift nor a rare talent but something that could be attained and practiced every day to get higher understanding and proficiency. How to make a good impression and spread sincerity in the doctor-patient contract is something that needs to be achieved to get better improvement and involvement. Professional workers in major companies and cities are constantly trying to impress their supervisors through walk-in interviews and presentations. Lots of books and literature are made to comprehend advice, ways, and many things to impress others. Communications have to work both ways and as physician especially anesthesiologist working with difficult patients in order to establish good rapport with patients or families, we also need to learn and work on our ways to communicate with them.¹³

There are several things to do to establish good rapport in doctor-patient communication especially in anesthesia-related problems.

1. Clarifying roles
From the 1976 Maguire and Rutter review of 50 medical students, about 80% of them were failing to introduce and clarify their roles in patient treatment. Although this might be looked simple, a careful introduction about our name, job description, and disclosures that clarify our roles as part of health care team would be very respectful to make a good contact with the patient. The patient would feel treated as an individual with integrity and his/her rights of involvement in medical treatments are honored.¹³

2. Attentive listening
Listening does not only restricted on hearing patient’s answers and complaints but more about not interrupting and to be present psychologically and emotionally. Because of their limited working timeframe, anesthesiologist rarely gives time to the patient to explain more about their opening statements. Waiting time, facilitating response, even non-verbal skills and cues are needed to develop an attentive listener. By listening, anesthesiologists could improve their negotiation and observation skills with their patients. With a simple negotiation, a good rapport could be built and sustained.¹³

3. Frameworks integration
Doctors and patients are looking towards the same present problem but both use different...
frameworks to view and gather information in history taking. Patients are using illness framework emphasizing their concerns and feelings about illness experience. In other hand, doctors are elaborating symptoms and signs through thorough investigations to enlist several differential diagnoses. Doctors should integrate those two frameworks to have better understanding and decision-making to define a present problem.1,3-9

Clarifying information and histories, use signposting to build a sensible bridge between several disclosures and statements, summarize internally with the patient and finally develop logical sequence would help doctors to integrate both frameworks.1,3-9

4. Building the relationship

The doctor-patient relationship is very unique, not only based on contract but also involving trust. Building a solid trust between two different persons from different background and was met for the first time could be done when both sides are willing to connect personally and explain problems truthfully. Use decent eye contact to show willingness and sincerity, make open questions to dig more from the patient, use non-verbal communications such as polite touches, gestures, smiles and nods to show some expressions to confirm understanding and respect. Somehow doctors could also pick up verbal and non-verbal cues to emphasize patient statements and sequences. Another important thing is to accept patient responses in a non-judgmental manner. Each person could have their own opinions about their sickness and underlying treatment, respect and empathy are needed to maintain steady and professional communication skills.1,3-9

By considering cultural history and background, doctors would also be regarded as human and partner in the whole situation. Food abstinence, honoring certain traditions and local customs, even allowing families perform harmless rituals could help to boost a good relationship with patients and surroundings. Ensure patient comfort even in hospital settings would conjure good vibes and maintain patient progress and doctor targets at the same pace.4,7,9

5. Be a team player

Becoming anesthesiologist is definitely to be a good team player. Good team player has to be communicative, supportive, flexible, unselfish and interested in the success of the team. Liaise with operating room personnel/physiotherapist/family/nurses/social care workers to ensure that a thorough patient management plan is in place to ensure optimum care. A number of studies have revealed the characteristics of successful team, which are described as3-9

- A meaningful, clearly defined task
- Clear team objectives and individual targets
- Regular meetings
- Regular feedback to individuals and the team’s success in achieving objectives
- The right balance of people
- The ability to reflect on team performance and adapt and change
- The experience of full participation, which reduces stress and may lead to better care
- Good leadership

A good team shows excellent internal and external communication. External communication means keeping the team in touch with what is happening in the wider organization and letting the organization know about the team. Internal communication involves making sure that everyone has a voice so that risks can be appreciated, problems aired and the best care was given. Anesthesiologists are highly appreciated if they could take part in improving internal and external communication, somehow giving examples of good leadership. Keys and tricks to communicate with other theater personnel, especially the surgeon, are in feedbacks. Several things need to be considered in giving and taking feedbacks as anesthesiologist:3,6-10

- Feedback should be descriptive rather than judgmental or evaluative
- Describe the situation that was happened during observations and monitoring to the surgeon. Share our thoughts about it and ask for opinions from the surgeon.
- Make feedback specific rather than general.
- Timing and the specific situation would help others to understand and quickly reevaluate a critical condition. Avoid general descriptions that would be unnoticed and unseen.
- Focus feedback on behavior rather than personality.

Different personnel would have different personalities. Socializing and frequent adjustments with characters are needed to improve our way of communication especially in giving feedbacks. Different personality type would need the different type of getting feedbacks also. Polite, distinctive and scientific feedbacks would get more appropriate attention.

- Focus feedback on sharing information rather than giving advice.

Each personnel has their own competencies and privileges, and neither of them would
like to accept advice gladly. It is better to give feedback in information sharing manner rather than advisory type.

- Give feedback about something that can be changed.
  Available and vivid solutions will always be preferable than unclear suggestions. Something that could be changed and repaired quickly would always be more appreciated than just mere ideas.

According to Dr. Gaba, there are several things that caused inertia in operating room communication especially between the anesthesiologist and surgeon:

1. Natural reluctance to interrupt.
   An anesthesiologist is already internalized as second in command in operating theater and responsible for the surgery and anesthesia implementation. Delay and cancellation seem to be a ‘shame’ for an anesthesiologist.

2. Fear of embarrassment.
   Different levels of knowledge and experience would lead into different expertise and comment about upheld situations. Seniority and competency issues would make inferior personnel feel embarrassed and uneasy to speak their mind.

3. Concern about being misjudged/conflict.
   Disputes and different opinions about illness and disease between medical personnel are widely seen but never been confrontational or conflict-induced. High concerns regarding misjudged or conflict potential made important feedbacks are better held and unsaid. One additional influence is the phenomena of “social shirking” or the “bystander effect”—the expectation that someone else will take action so that yours isn't needed.

4. Fear of being wrong and concern for reputation.
   Working years of experience is highly praised in the cutting specialist. The more and the longer you work, your skill is increasing and would gain much respect from others.

5. Fear of outright retribution.
   Without deeper understanding, giving comments and feedbacks would be seen as interference and would make several parties irritated.

6. Don’t know what to say or how to say it.
   Tiresome working hours and unfriendly relationships in the operating theater would only make personnel confused and could not define clearly their remarks and feedbacks. They would feel reluctant and better to keep their mouth shut.

There are different types of approaches to using effective speech to help overcome these barriers and to get others to share your concern without becoming defensive. One such approach that was suggested is using advocacy or inquiry. This involves maintaining curiosity and trying to learn other person's point of view. At first, we should state our observation as express facts which take concern.

Be curious about their point of view because there is still a chance they are right. This technique takes a lot of practice, but it can be very useful in many life situations once it’s mastered.

Another way is using a rule called two-challenge rule which was developed in aviation. The common objective of the technique is to get the team to focus on what’s right for the patient, not who is right. In situations prone to accidents when co-pilots did not successfully challenge a pilot's errors or misjudgments. Firstly, raise our concern in a non-confrontational tone. If it is not acknowledged, repeat with more emphasis. If the second challenge is not acknowledged, refer the issue to another person, such as supervisor with authority to intervene or other trusted colleague.

Communication skills are connected with leadership and self-confidence within the anesthesiologist themselves. Since 1999, Dr. Francis M. James III had outlined both the importance of leadership in medicine as well as the breadth of leadership opportunities available both inside and outside anesthesia. Anesthesiologists need to become an agent of change who could envision, lead and implement initiatives that ultimately result in patient safety, improved quality and technological innovation. Effective leadership is essential for anesthesiologists to succeed in this transformation because it would envision and guide their team in the hospital through change. Effective leadership with a focus on managerial skill is undoubtedly needed in this case and the key point of managerial skill requires a good communication skill.

There are three points to make a practical framework for leadership in anesthesia practice. They are self-awareness, creativity, and relationships. In self-awareness, accepting personal accountability is the first potential step to turn a negative situation into the opportunity for learning and growth. Self-awareness is the core of emotional intelligence according to Goleman which could be defined as an ability to accurately appraise and express emotions, regulate emotions effectively and to use it as thinking and action guidance. Creativity is defined as a willingness to experiment and open to innovative ideas has been shown to be important to become an effective
leader. In the time of change, the ability to adapt and open to creative talents inside and out should be nurtured in every anesthesiologist. Relationships are also critical in supporting leadership. Relationships based on trust and encouraging supportive dynamic team would enhance other points of a framework to build a practical leadership. Those three points are interconnected with each other and practical leadership is also work as a continuing process that requires the three points in an interconnected way. Communication skill could be the thread line to weave those three points to make a good practical leadership framework. Based on good self-reflection and awareness, a supportive communication between anesthesiologists and the operating team would be improved, creativity would also be nurtured in an effective communication circumstance and triangular relationship between anesthesiologist-patient-surgeon is well maintained with excellent communication skill.

Training in communication skill needs to be implemented in all level of education and leadership. As we know leadership is not defined as authoritarian environment anymore, but more as an interpersonal endeavor that could start in every individual as the own leader of themselves. Communication skill should be viewed and trained as continuous lectures and practices in daily basis to build and improve self-confidence and self-competence for us to interact with another person not only as anesthesiologist but also as an act of humanity.

REFERENCES

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