QUICK LESSON

Legal Issues...Communication Barriers: an Overview

Issue Description

Effective communication is a two-way process – sending a clear message that is correctly understood. Communication is an important part of effective patient care.[38] A lack of communication between caregiver and patient is usually caused by the patient being unable to speak or understand English and having low literacy.[52] Not to be ignored is the large number of caregivers in the US whose primary language is not English and who speak English with heavy accents, thus impairing communication with patients who have a different primary language than the caregiver. There are also other causes of poor communication, specifically, deafness, and dysfunctional communication between caregivers.

Patient disability can take various forms. These include developmentally challenged patients, psychosis, inability to speak (aphasia), deafness,[53] and even patients who, for whatever reason, refuse to communicate adequately. In the UK, learning disabilities caused inadequate communication between many people and their physicians.[1] In particular, women with learning disabilities did not receive information about contraception that they could understand.[2] People with learning disabilities have difficulty conveying to caregivers that they suffer pain and the extent and location thereof. They convey emotional reactions to pain rather than describing the pain itself. Caregivers incorrectly believe that people with learning disabilities possess a higher pain threshold than other people. The consequence of poor communication in this segment of the population, is that they rarely seek the care of physicians in comparison to others, although they suffer more health problems.[3] Immigrants in the Netherlands reported dissatisfaction with medical treatment due to lack of communication with care providers. Also, they understood that they, and not the care provider, were responsible for interpreter services.[4]

Dysfunctional communication between caregivers can be between physicians and nurses, between RNs and patient care assistants,[5] between nursing homes and acute care centers, and between hospitals when patients are transferred from one to another.

An Australian study found that there was poor communication between midwives (OB/GYN registered nurses) and practitioners of naturopathy and herbal medicine (CAM –complementary and alternative medicine). This may partly be due to pregnant women not telling midwives that they consulted CAM practitioners, possibly causing risk of harm to the patients. More highly educated midwives were less likely to be positive towards CAM practitioners.[43]Also in Australia, it was found that immigrant family practitioners with home languages other than English had difficulty understanding their rural patients in Western Australia whose vernacular included “grunting” sounds.[57]

Effective communication between clinicians is vital to safe and effective delivery of health services. A breakdown in communication is a factor in most sentinel events reported to the Joint Commission.[6] A weak point in communication occurs when one physician hands off responsibility for a patient to another physician. Handoffs can take various forms such as change of shift, the patient is moved to another area in the same hospital or is transferred to another hospital. If inaccurate and insufficient information is communicated, especially

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considering the patient's current state, this can lead to errors. One problem is the receiver's inability to draw inferences concerning non-explicitly stated information in a handoff. Another problem is that most handoffs are conducted via telephone thus depriving the receiver of visual cues.[7]

It was found that one in four requests by family practitioners for consultations with specialists did not contain a clear clinical question. There were also other communication breakdowns resulting in the specialist not possessing enough information during the initial consultation. With this in mind, medical informatics experts initiated a comprehensive study of communication problems that arise between the family practitioner and the specialist physician in a Veterans Administration medical center.[8] A journal article reported that the investigation focused on so-called "paper persistence", and the reasons for it, when electronic records should have been used.[9] However it was found that some paper-based workarounds offer efficiencies and other advantages over use of computers and even revealed defects in program designs. Details of the latter problems found are given in the article in table form.[10]

A survey was taken in Nigeria of 167 hearing impaired females aged 11-25 years. The survey investigated the nature and extent of communication barriers experienced when seeking reproductive health services. It was found that 41% of them could not make themselves understood. Likewise, 41% of them had missed their turn in the waiting room because they did not hear their names being called, showing that mundane details are important in providing health care. Over a third were embarrassed to ask questions in front of an interpreter.[42]

Serious problems with communication were found in an intensive care unit in a South African academic public hospital. The problems involved a lack of communication between caregivers themselves, between caregivers and patients' families, and between caregivers and patients. The worst aspect was lack of communication and collegiality among caregivers. The serious nature of patients' illnesses, and the technical skills required, tended to overshadow the need for interpersonal skills among caregivers. Cultural and socio-economic differences made the need for communication skills all the more acute.[11]

A researcher in Sweden commented on the progress made in her country to permit full accessibility in society to those suffering disabilities.[12] Although there had been improvements in physical disabilities, there were fewer changes made to accommodate those with less visible disabilities. Examples of these disabilities include stroke, traumatic brain injury, neurological degenerative disease and aphasia (impairment of speech). In particular, it is necessary that communication partners of those suffering aphasia receive adequate training so that a "communication ramp" is provided in healthcare settings. This will enable aphasia sufferers to communicate their thoughts, opinions and knowledge. As a result they will receive better health care and be able to deal with common issues of life such as housing and household budgets after discharge from hospital.

It was observed in Denmark that an activity as mundane as assisted feeding of the language impaired stroke patient requires physical coordination between caregiver and patient. This can only be achieved by a rapport developed by verbal and non-verbal communication between caregiver and patient.[35] Assisted feeding can then "be a healing activity creating a basis for recovery."[36]

Researchers in Australia studied barriers to communication in acute stroke units and ways to remove those barriers. One surprising barrier was the caregivers' lack of awareness that stroke patients suffer communication-related impairments, indicating a need for screening for those impairments. Caregivers also need to acquire knowledge of different communication impairments so they can select correct techniques of coping with them. Lastly, a caring attitude by caregivers who respect their patients enhances the quality of communication.[13]

Some of those who become deaf at an early age identify themselves as culturally deaf thus alienating themselves from hearing people. They tend to communicate only in American sign language (ASL) and not by lip reading. This segment of the population is rarely screened for depression by psychiatric and advance practice nurses as is routine for hearing patients. Thus culturally deaf adults usually do not receive the mental health care that they need. Psychiatric and advance practice nurses should advocate for deaf patients by communicating in ASL if the patient does not lip read.[14]

Language and cultural barriers in Ireland between nurses and immigrants (now comprising 12% of the population) gave rise to concern among nurses that they could not make an optimum assessment to form the basis of a quality care program for the immigrant patient. Use of interpreters is not always successful[41] but could be improved by the development of a "Translation Standard" of medical terms.[54] Continuing education is needed for nurses to become culturally competent.[41] For a discussion of cultural competency see *Legal Issues…Communication Barriers: Language.*

A different result was found in a survey conducted in Los Angeles and Seattle of 185 Spanish-speaking obstetric and gynecological patients suffering pain. Interpreters were used to assist physicians in diagnosing and treating the pain of half the patients while no interpreters were used for the other half. The patients for whom interpreters were used reported better pain control than the others.[(45)] Similarly, a Massachusetts survey of 3071 limited English proficiency inpatients showed that length of stay increased for those who did not receive interpreter services on admission and discharge and they also were more likely to be readmitted within 30 days.[(47)]

Medical jargon incomprehensible to the patient can be a significant barrier to communication even when the patient is English-speaking. Interviews in Chicago with low-income English-and Spanish-speaking women suffering breast and cervical cancer, indicated that jargon is not used when health information is communicated in Spanish. On the other hand the English-speaking patients complained that they could not understand the English medical jargon.[(46)] Native Hawaiian and Filipino women in Hawaii aged 40 years and over did not understand their cancer diagnosis but did not ask questions due to shyness and because they did not want the doctor to think negatively about them.[(51)]

Definitions

› **Opioids:** Synthetic narcotic not derived from opium.[(15)]

Risks

Failure to communicate with a patient, for whatever reason, can have serious consequences, including wrong diagnoses, lack of informed consent, and failure to understand discharge instructions. A failure to communicate can occur in most settings such as the emergency department, medical/surgical, and critical care. Some units have their own inherent problems of communication such as pediatric and psychiatric units. However caregivers in these units are trained to cope with communication problems as being an integral part of caring for these patients, and not just an intermittent problem.

Where there are marked cultural differences between patient and clinician, mistrust, suspicion and bewilderment on the part of the patient can lead to a lack of communication between them. A typical example is the *Rivas* case where a Spanish-speaking father of a very sick baby appeared to be unable to communicate with physicians who needed to perform surgery on the child.[(16)]Cultural differences formed a barrier between nurse and patient in Southern Spain because nurses had difficulty in communicating effectively with Moroccan immigrants. The barrier was exacerbated by nurses' prejudice and stereotyping of the patients.[(48)] HIV prevention counselling in the Democratic Republic of the Congo was hampered by healthcare workers' ignorance of young patients' cultural and religious beliefs about sexuality.[(50)]

One instance of a large-scale failure to communicate adequately with patients occurred in the UK. A public information campaign was launched to inform patients that their confidential medical records were being made available for the first time to multiple providers in electronic form. The main method of communication was a letter addressed to each patient by name informing them of the change. However, the letter was criticized as being badly presented with the result that many patients discarded it unread.[(17)]

It was found in a university hospital in Turkey that nurses experienced communication problems with "difficult" patients for various reasons such as demanding too much attention, complaining, and rejecting treatment. It was concluded that these nurses needed to develop basic communication skills and acquire problem solving techniques.[(18)]

A researcher in Milwaukee suggested that physicians receive continuing education to improve their communication skills to enable them to discuss with patients the sexual violence to which they have been subjected. This will enable their patients to begin the healing process.[(19)]

In 2007 a large survey in California showed that limited English proficiency among Latino, Chinese, Korean, and Vietnamese people made them much less likely to be able to obtain and understand basic health information than white people who are mainly proficient in English. This placed them at a high risk for poor health.[(37)]

Units Potentially Involved

According to a Chicago study in 2009[(20)] a lack of communication and hostility between hospice providers and nursing homes and private homes, impedes palliative care for their mutual patients. Caregivers' emotions, including fear of patients' opioid addiction, influence decisions and methods of caring for those suffering chronic pain. Another fear was that the caregivers might cause the patient's demise. Territorial feelings ("this is my turf") impede open communication between nursing

home providers and palliative caregivers. Often these turf battles result in pain management recommendations by palliative caregivers being ignored.

The Chicago study investigated some of the following settings:

- ***Hospice and private home:*** Similar emotions, as described above, prevail in private homes as well as in nursing homes. Family caregivers worry about the social stigma of opioids. Some are concerned that addicts in the family will have access to drugs. Others are embarrassed to request advice or to reveal prior mistakes and express worry about what the hospice worker would think.[(21)] Family caregivers also view their homes as "sacred" space and this feeling of ownership somehow translates into a defiance of hospice workers' instructions based on the family caregivers' view that they know what is best for the patient. Even grief for the patient can create a barrier to communication. This creates difficulties for hospice workers in reconciling their duty to the patient with their attempts to respect family caregivers' feelings. The problem is not alleviated by the presence of privately-hired caregivers who also defy hospice workers' instructions, based on fear of loss of control. A reluctance to abdicate control can place the patient in danger when medications are involved. One example given of this danger was the chaotic way medications are stored, with pills lying around. Some family caregivers justified their lack of cooperation by citing prior adverse experiences with the medical establishment which included hospice nurses. Miscommunication arose when families did not designate a primary caregiver at the home so the hospice provider did not know who should receive instructions. On one occasion a patient received a double dose of medications, from the husband who came home first and then from the wife. Poor family leadership resulted in the home healthcare worker not being authorized to give drugs to the patient while the family also omitted to do so. The hospice worker complained that she was forced to visit every day to administer required drugs. Family dynamics, including deep-seated conflicts, impeded hospice workers from performing duties, with hostility between family members causing obstructionism. As a result the patient did not receive proper treatment. Another severe problem causing miscommunication is that family members have their own lives to live and are distracted by family responsibilities, jobs and household chores. Hospice providers struggled to educate family caregivers in properly balancing the comfort of pain medications against its sedative effects. Family members wanted the patient's alert companionship but the hospice workers noticed the pain they suffered in the process.

Another study found that a deterioration in communication causes stress and loneliness for spouse caregivers of Alzheimer's disease patients and these caregivers need educational programs to improve communication skills.[(22)]

- ***Hospice and nursing home:*** Hospice providers experienced barriers to communication when guiding nursing home staff in the palliative care of patients. Part of the reason was the difference in the education and training received by hospice providers and nursing home caregivers with the latter not being fully aware of the function and effect of the different medications. Misleading information accessible on the internet did not help. Another reason was the preexisting relationship between the nursing home staff and the patients. Sometimes relationships bordered on hostile and suffered from lack of interest in the patient. One example given was the refusal by nursing home staff to give pain medication to a patient who was obviously in severe pain. Part of the reason for such a refusal is fear of causing the patient's demise with morphine. A solution suggested by hospice providers is to cultivate trust to encourage cooperation. One hospice caregiver said that she had been working at a particular nursing home for six years and even if the staff had reservations about her methods, they still trusted her judgment and let her administer medications. Hierarchies at nursing homes created barriers to communication, with nursing home physicians overruling hospice providers' decisions even when the hospice provider knows the patient is in pain. Sometimes a change of shift caused problems when instructions were not passed on to the new shift. Dysfunctional leadership at nursing homes resulted in a lack of teamwork and defective communications among staff – medications orders by one nurse were overturned by another. A director of nursing at a nursing home was "disagreeable and argumentative" and stopped a medication order without notice requiring hospice providers to visit the nursing home more often. Other symptoms of dysfunctional leadership: (1) Allocation of too many duties to nursing home care providers –examples given were med passes for 40 patients at once and several prn drugs ordered every one to two hours. (2) Failure to prioritize pain management – examples given were the inappropriate focus on restoring patients' physical functioning while neglecting their pain, and worrying about drug addiction of patients with less than six months to live. Finally, the different aims of hospice providers (comfort care) and nursing home providers (maintenance of physical functioning) erected barriers between them.
- Many oncologists in Canada have difficulty in effectively communicating end of life issues to their patients. Reasons for this include lack of training with few mentors available, physician discomfort with death, and opportunities for "passing the buck" to colleagues.[(49)]A Los Angeles newspaper journalist whose husband died a slow death from an inoperable brain tumor complained that "The two words most doctors avoid saying: You're dying." She said they use euphemisms such as "Treatment isn't going our way" or they "could no longer help" him. Technology has become so complicated that doctors

type computer notes while they speak with patients, thus hindering communication. She said that medical school training on death and dying is deficient. [56]

- Care of cancer patients and communication with them and their families is especially difficult for nurses due to the emotional load that they, their patients, and patients' families have to bear. In Singapore nurses found it difficult to respond to patients' questions especially when they have to give an unfavorable answer. Communication was also made difficult by patients' and their families' lack of respect for nurses.[38] Palliative care of cancer patients, namely, Moroccan and Turkish immigrants, in The Netherlands was made more difficult by cultural differences and language barriers. These patients were more passive with communication than Dutch patients resulting in physicians not learning enough to treat the patients adequately. Language barriers also contributed to the problem. Both care providers and patients' families did not favor using interpreters. The former thought that this would waste time and the latter feared that the interpreter would be too blunt in giving "bad news" information to the patient.[33]
- ***Long-Term Care:*** Barriers to communication between nurses and physicians in long-termcare settings start with the telephone which is the most frequent method of communication between them. Barriers to communication include the timing of calls, namely, after hours and on weekends (when calls were not welcomed by the physician) and the physician's lack of familiarity with the patient. A study of this problem revealed further problems that nurses experience. Many nurses felt that the physician did not want to deal with the issue presented, that they did not take the nurses' views into consideration, or they felt hurried by the physician and that they were bothering him. Add to this the difficulty in finding a quiet place to call, difficulty in reaching the physician, and delays in returning calls. Even worse was disrespect and rudeness, even anger, towards nurses, including interruptions before completing the report. On the other hand some nurses reported that their preparedness could improve to enable them immediately to respond to the physicians' requests for pertinent information. However returned calls reduced the nurse's preparedness because other tasks prevail when the call was returned. A solid professional relationship between nurse and physician seemed to be the most effective way to improve communication.[23]
- ***Intensive Care Unit:*** Communication with patients can be problematic in the intensive care unit. Successful steps to improve the ability to communicate will improve health, reduce length of hospital stays, and hasten rehabilitation.[24] When a patient cannot speak, practical methods of communication include written notes, gestures, pictorial notes, coded eye blinking, coded eye gaze left to right, and exaggerated mouth movements by some patients. A tracheotomy in situ causes communication problems that last as long as the tracheotomy is in place. Those patients who have not suffered paralysis of, or damage to, their vocal chords can exercise a number of options for vocal communication. One of these is partial cuff deflation so air can pass through the glottis to allow speech. There are also other devices available such as the Passy-Muir Valve. Where the vocal chords are non-functional a speech and language therapist may advise the use of an "artificial larynx".
- ***Operating Room:*** Communication failures among operating room personnel are frequently caused by "status asymmetry" and high-tension situations. Nurses ranked surgeons' communications skills high only 48% of the time while surgeons ranked the communications skills of other surgeons high 85% of the time. It is significant that a higher incidence of better patient outcomes occurred when nurses held a favorable opinion of team members' communication skills in three intensive care units in New York State. Especially in cases of "status asymmetry", for example when a perioperative nurse disagrees with a surgeon's views or actions, a method of challenging a fellow team member's actions is to copy and adapt United Airlines' pre-formulated non-accusatorylanguage such as "I'm concerned" and if no response follows, "I'm uncomfortable this is unsafe" and so on. Another, more fundamental solution is to change hospital culture so as to make challenges to errors acceptable.[25]Communication failures also occur preoperatively between anesthesiologists and surgeons, after surgery in the handover, and in daily unit care.[34]
- ***Cardiac Units:*** Research in two educational hospitals in Tehran, Iran revealed a dysfunctional relationship in cardiac units between nurses on the one hand and physicians and nurse managers on the other. The hierarchical structure possessed features of paternalism, lack of collegiality, low nurse autonomy, lack of respect to the extent of contempt, and lack of support. Nurse participants were 78% women and physicians were 50% women indicating that the poor relationships were probably not primarily gender-based. Poor professional relationships led to poorer patient-care outcomes. Cardiac patients in the same hospitals who were interviewed expressed dissatisfaction with the standard of their communications with nurses and physicians. Nurses were curt with patients and cut conversations short. Nurses and physicians used too much medical jargon without explanation.[26]

Emergency Room: Physicians do not routinely screen for intimate partner or domestic violence (e.g., wife battering) even when treating injuries. Barriers against such screening include difficulties with language, patient's reluctance to disclose what happened coupled with the healthcare provider's fear of offending the patient, and lack of training in managing these

situations.[39] In Queensland, Australia immigrants who do not speak English at home used the emergency room between 2008 and 2010 less than those who speak English at home.[40]

Perhaps adverse effects of inadequate communication can sometimes be overcome. A study was made of the history of the present illness accompanying 100 Pennsylvania patients who were transferred from nursing homes to a level 1 community trauma center. The history was adequate in only 35% of the patients. However a history could be obtained for 68% of the patients from either nursing home records, nursing home personnel or the patients themselves. Despite those deficiencies, the number of admissions, quality of diagnostic testing and patient turnaround time were all the same.[44]

Court Cases

***Deafness*:**In Maryland, Erick Posner filed a claim[27] for compensatory damages under Section 504 of the federal Rehabilitation Act of 1973. Mr. Posner was admitted to the hospital for heart palpitations, light-headedness,and throat discomfort. Although he was deaf, could not lip-read, and was unable to speak, he was not provided with an interpreter during his stay in hospital. However he could read and write. On admission his companion requested an interpreter for him and the nurse asked him whether he would prefer a live interpreter or Deaf Talk, a remote sign language interpreter service on video conference. He chose Deaf Talk by circling that option on the nurse's note. However Deaf Talk was never provided and Posner claimed that he could not communicate or participate in his care. He did not even understand his condition upon discharge. The hospital had a written policy to provide an effective medium of communication with hearing-impaired patients and nurses were responsible for providing the interpreter services that the patient preferred. There was a dispute whether the hospital provided adequate auxiliary aids to Posner. The hospital admitted that it provided neither a live interpreter nor Deaf Talk to Posner but contended that Posner said he preferred to speak or write and would use Deaf Talk if needed, but managed to communicate effectively through speech and writing. The hospital contended that Posner had no claim because he could not show the requisite intentional discrimination. The court ruled that intentional discrimination does not require hostility towards the plaintiff. The hospital can intentionally violate the Act even if it had the best of intentions towards the plaintiff and believed that it was in compliance. Further, an intentional violation can occur if the hospital harbored a deliberate indifference to the strong likelihood of a violation, for example, if a patient repeatedly requests an interpreter and the hospital makes only a few unsuccessful phone calls to try to obtain one. The court ultimately denied the hospital's motion for summary judgment (judgment in its favor without a trial) on the basis that there were genuine disputes of material fact between the parties.

***Cultural Problems*:** Where there are cultural differences between patient and clinician, mistrust, suspicion and bewilderment on the part of the patient or parent can lead to lack of communication between them.[28] A typical example is the *Rivas* medical malpractice case, partially based on a lack of informed consent, where a Spanish-speaking father of a very sick baby appeared to be unable to communicate with physicians who needed to perform surgery on the child.[29]

***General*:** In an administrative action[30] by the California Department of Public Health a penalty of an undisclosed nature or amount was levied against Sharp Chula Vista Medical Center after it declared that the hospital had placed patients in "immediate jeopardy". The patient had respiratory failure, pneumonia, diabetes and a history of hypertensive heart disease. He was given heart surgery during which five bulldog clamps were used. Towards the end of the procedure one was unaccounted for so the surgeon searched the wound but could not find it. An X-ray was therefore taken. The X-ray technician said one of the OR nurses told him they had to look for a tiny piece of equipment called a "bullnose something" and showed him one. The technician took the X-ray and transmitted it to the radiologist who was not on site. The X-ray order was reviewed by the X-ray technician but it gave no information on why an X-ray was requested. The radiologist said he called the technician and asked him exactly what to look for. The technician told him it was a bullnose retractor (which is a large instrument). The radiologist examined the film and told the technician he saw no bullnose retractor. The radiologist did not call the OR to discuss his result. The technician said he would tell the OR team. The wound was then closed up, and the surgery completed. The radiologist said he had never heard of a bulldog clamp so he would have asked what it was if he had been told it was that item. The technician denied that he told the radiologist to look for a bullnose retractor. A few days later, a CT scan showed a metallic foreign body in the chest and ten days after the initial surgery the bulldog clamp was surgically removed from the patient's chest. This case is a classic example of serial miscommunication due to carelessness, lack of focus on the job at hand and laziness. There were opportunities to convey the correct information to the technician (oral instructions) and to the technician and radiologist (the written order). The technician should have paid more attention to the oral instructions and should have insisted on a full written order. The radiologist should have asked to see the written order. He also should have called the OR and reported that he found no bullnose retractor which would have alerted the OR staff to the error.

Failure to communicate test results: A California doctor ordered a cystic fibrosis blood test for his pregnant patient. The test was taken at a hospital which forwarded the results to the doctor. The test results indicated that the baby would suffer from cystic fibrosis. However the doctor did not convey the results to the patient and the baby was born suffering from that disease. The patient sued the doctor and the hospital for not telling her about the test results. The doctor could have informed her during several subsequent consultations. The doctor contended that the hospital, and not he, had the duty to inform the patient of the results. The court disagreed and granted summary judgment in favor of the hospital. The doctor appealed. The appeal court held that the hospital's duty was to send the results only to the doctor and not to the patient. Federal law as set forth in 42 Code of Federal Regulations §493.1291(f) requires test results to be sent only to authorized persons. The latter are defined in 42 Code of Federal Regulations §493.2 as individuals authorized under State law to order or receive tests, or both. California Business & Professions Code §1288 provides that test results may be sent only to licensed health practitioners which in this case was the doctor that ordered the test. The court also accepted the expert testimony of a pathologist who testified that reporting test results direct to a patient is not an accepted practice of the clinical laboratory profession and falls below the standard of care.(55)

Recommendations

In 2008 the Joint Commission published recommendations for clear and complete communications between health care providers which they regard as essential for safe patient management.(31) In 2001 the federal government published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), see *Quick Lesson About Legal Issues…Communication Barriers: Language* . Unfortunately, health care organizations have not yet met these standards. For example, some reported that they informed patients of their right to receive language services but did so only in English. Some used family members or other untrained interpreters to interpret for patients.(32)

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