EXTRACTS FROM THE MAIN BOOK

Communicate. Care. Cure.

A GUIDE TO HEALTHCARE COMMUNICATION

Third Edition

Edited by
Dr Alexander Thomas

Foreword by
Dr Devi Prasad Shetty

Note from the Publishers

The AETCOM (Attitude, Ethics and Communication) Competencies were recently introduced into the medical curriculum by the Medical Council of India. The foundations of communication outlined in the syllabus include the skills of communicating with respect and empathy, active listening, verbal and non-verbal communication, data gathering, and full disclosure of medical errors, among others. These topics and more are covered in the book Communicate. Care. Cure. A Guide to Healthcare Communication. Written by healthcare professionals and communication experts, it contains real-life scenarios that take place in healthcare settings today. This booklet contains extracts of chapters from the book for promotional purposes. This sample is intended to give the reader an idea of the structure and contents of the main book. It is our sincere hope that students will find the complete book useful in achieving AETCOM competencies as they begin their careers in healthcare. We would be delighted to hear your feedback at marketing@wolterkluwer.co.in

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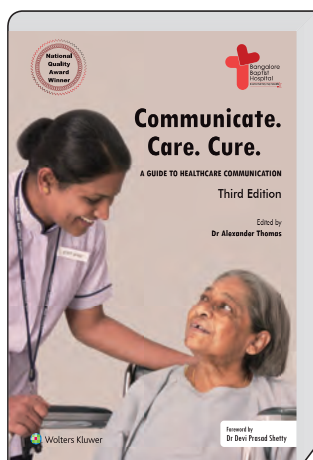

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Chapter 2

Verbal Communication Styles

The Role of Assertiveness in Healthcare Communication

V. Kingsly R. Gnanadurai

Let's build bridges, not walls.
– Martin Luther King, Jr

There are four ways in which people verbalise their response to situations: aggressive, passive, passive–aggressive (P–A), and assertive. Let us examine these styles of communication, using typical hospital-based scenarios and noting important individual and social characteristics associated with each style.

Aggressive communication

Dr Anand is making his rounds in the ward when Nurse Anita notices that he has not done anything about the uncontrolled sugars of a patient admitted with pneumonia.

Aggressive Anita: *(Loudly) Doctor, the patient's sugars are high. You haven't said anything about that.*

Aggressive Anand: *(In loud, irritated voice) Nurse, don't tell me what to do. I know how to manage my patients. Just follow my orders – that's what's expected of you.*

Aggressive Anita: *(In equally loud, irritated voice) Excuse me, Doctor. I'm also a part of the healthcare team. You've no right to talk to me as you just did! I'm going to file a complaint at the Nursing Office against you.*

This example illustrates the aggressive style of communication on the part of both Nurse Anita and Dr Anand. The first statement, made

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loudly by Anita, perhaps provoked Anand to retort in a rude and condescending manner. Anita's reply to him may further aggravate the situation.

Aggressive communicators are impulsive, loud, and blunt. They try to blame or shame someone else. They are sarcastic, controlling, manipulative, and self-centred. They are poor listeners who interrupt frequently. They have low self-esteem.

Aggressive communicators tend to dominate the other person in the conversation and win an argument: they create win–lose or lose–lose situations. (The scenario above was clearly the latter.) Such communicators, perhaps because of their low self-esteem, attempt to put others down, believing that only by being controlling and using force can they have their way. Aggressive communicators may succeed in the short term but, in the long run, stress others out considerably and end up socially isolating themselves.

Passive communication

This time, Dr Anand is on rounds with Nurse John, a passive communicator:

Passive John: *Doctor, the patient's sugar levels are high.*

Aggressive Anand: *(In loud, irritated voice) Nurse, don't tell me what to do. I know how to manage my patients. Just follow my orders – that's what's expected of you.*

Passive John: *Oh, I'm really sorry, Doctor. I shouldn't have spoken out of turn. (The rounds are completed with no further information volunteered by Nurse John.)*

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As we can see, Nurse John avoids confrontation. The passive communicator avoids conflict at all costs, even if it means being used like a doormat.

Passive communicators allow others to infringe on their rights. They do not express their feelings, opinions, or needs. They believe that other people's needs are more important than their own. Passive communicators remain silent out of fear. They, too, feel insecure and have low self-esteem. But they believe they are the victims of circumstance.

Passive communicators create lose–win situations. They believe that if they speak up, others will ignore or reject them. They usually have a tough time recognising their needs and learning how to fulfil them.

Passive–aggressive communication

Now, Dr Anand is doing rounds with passive–aggressive (P–A) Nurse Padma:

P–A Padma: *Doctor, the patient's sugars are high.*

Aggressive Anand: *(In loud, irritated voice) Nurse, don't tell me what to do. I know how to manage my patients. Just follow my orders – that's what's expected of you.*

P–A Padma: *(Putting on a smile) OK, Doctor. (Hissing behind back) You fool, just you wait until my time comes! I'll make sure a patient complains about your incompetence.*

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Nurse Padma communicates passively, but only superficially. She has hidden her aggression, and is resorting to masked communication because she feels powerless to address the issue head on.

P–A communicators believe that they are powerless, feel stuck and resentful, and mutter to themselves rather than speaking up to the person about an issue. Outwardly, they deny that there is a problem. They have difficulty acknowledging their anger and, when experiencing negative emotions, use facial expressions that do not match their feelings. They subtly use sabotage and guerrilla tactics to get even. When they do not get their way, they pretend to cooperate but covertly work to annoy others or be disruptive. The P–A communicator stresses others out, widens conflicts instead of resolving them, and causes lose–lose situations.

Assertive communication

Dr Anand is now on rounds with Nurse Asha, an assertive communicator:

Assertive Asha: *(In level voice) Doctor, I wanted to tell you that when I checked the sugars of the patient, they were high.*

Aggressive Anand: *(In loud, irritated voice) Nurse, don't tell me what to do. I know how to manage my patients. Just follow my orders – that's what's expected of you.*

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Chapter 3

Actions Speak Louder than Words

Nonverbal Communication

V. Kingsly R. Gnanadurai

I trusted you, but now your words mean nothing because your actions spoke the truth.
– Anonymous

Nurse Latha has just started her shift and is at Mrs Chinmay's bedside in the female ward.

Nurse: *(To patient) How are you feeling today?*

Patient: *(In a low voice, with pained expression) Fine.*

Nurse: *Great! Have a nice day.*

Nurse Latha has not picked up the nonverbal cues. She has taken the patient's words quite literally and missed an important message.

Nurse: *(To patient) How are you feeling today?*

Patient: *(In low voice, with pained expression) Fine.*

Nurse: *Are you? I can see that you are in pain, and uncomfortable. Is the pain bothering you?*

In this case, the nurse is tuned in to the patient and has connected well by identifying the nonverbal cues and not just the words.

Nonverbal communication is communication that does not use words. A patient's nonverbal behaviour deepens the understanding gained by a physician of the patient's state of health. Nonverbal communication is thus an important tool for diagnosis, according to

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a study by Frankel et al. from the Johns Hopkins Institute, Baltimore, Maryland.[1] A physician's nonverbal behaviour, too, has some bearing on a patient's satisfaction with his or her visit to the hospital and can influence compliance with the doctor's orders.

Since 1872, when Charles Darwin published a scientific research paper, "*The Expression of the Emotions in Man and Animals*," a lot of research has been conducted on nonverbal communication.[2] We know, for instance, that feelings and emotions are conveyed in different ways.

Types of nonverbal communication

The commonly observed types of nonverbal communication are facial expression, eye contact, gestures, personal appearance, tone and volume of voice (also known as paralanguage), colour, body language, touch, proxemics, and silence. We will look at each of these briefly (because each communication type is a full topic in itself, a detailed treatment of which is beyond the scope of this chapter).

Facial expression. As the well-known saying goes, "the face is the index of the mind," that is, a large part of nonverbal communication is revealed through the face, which makes emotions evident. Raising the eyebrows could mean disapproval or worry. Frowning might signify disapproval or being upset about something. Smiling usually conveys approval or happiness, and a blank expression indifference.

A study by Ambady et al. showed that a physiotherapist's smiles, nods, frowns, and other facial expressions were associated with short- and long-term improvement in physical and mental functioning among patients.[3] The study also showed that patients demonstrated poor improvement in physical and cognitive function when their physiotherapists demonstrated distancing behaviour, like looking away from the patients or not smiling at them.

Eye contact. Nurse Amy is teaching her patient, Rani, how to manage her life with her recently detected diabetes. She soon feels upset because she believes that Rani is indifferent to her advice: she hardly asks questions and never makes eye contact.

The eyes are an expressive part of our face. They undergo a number of changes and provide important nonverbal cues, including staring, looking eye to eye, and blinking. The different ways in which a person looks usually indicates a range of emotions being experienced – hostility, attraction, interest, etc. In many cultures, good or poor eye contact signifies self-confidence or a lack of it, respectively. Among

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most Asians, Arabs, Native Americans, and Hispanics, however, it is impolite to look an elder or someone influential (e.g., a health professional) in the eye. Sometimes, a man in direct eye contact with a lady may be viewed as socially aggressive.

Patients generally prefer the attending health professional to make eye contact with them rather than have them keep looking at charts in their presence.

Gestures. These are deliberate body movements used to convey specific messages, for example, pointing and indicating numbers using fingers. Some gestures are culture-specific, for example, waving the hands to bid goodbye and shaking the head to say *no*. Head nods and gestures by physicians are generally found to produce higher patient satisfaction.

Personal appearance. The way we present ourselves to others is a form of nonverbal communication. The factors that contribute to our self-image are the way we groom ourselves, our attire, and our fashion consciousness. The attitude of a person is expressed through his or her personal appearance. Appearance has been shown to alter physiological reactions, judgements, and interpretations.

Tone and volume of voice (paralanguage). Paralanguage and paralinguistics concern those vocal aspects of speech – tone of voice, loudness, modulation and pitch, etc. – that are not part of actual language. This is very clearly evidenced in the strong influence that the tone of voice can have on the meaning of a spoken sentence.

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A clear tone of voice is often interpreted as approval or enthusiasm. The same words said in a muffled voice might convey frustration or lack of interest.

From numerous studies conducted on the tone of voice, we know that the negative tone of a patient's voice adversely affects the way his or her physician reacts to him or her[4] and that, among patients of alcohol misuse, a physician's hostile tone of voice leads to poor follow-up of the patient.[5] In a study done to identify whether the voice tone of physicians was related to lawsuits being filed against them, it was found that physicians using dominant and anxious tones led to poorer patient satisfaction and a higher probability of being sued.[6] Physicians who exude warmth and sincerity through their voice tones are less likely to have their patients switch doctors.

Colour. According to the Santa Barbara, California–based Institute for Colour Research, not only do people make a subconscious judgement about a person, environment, or product within 90 seconds of initial viewing, but 62%–90% of that assessment is based on colour alone.

Colour stimulates the nervous system and can influence moods and human reaction and, consequently, the healing process. The pioneering North American colour consultant Faber Birren determined that bright and vivid colours could arouse and increase autonomic functions, blood pressure, heart rate, and respiration rate and direct a person's attention outward, while, conversely, dimness and softer colours could create an inward response of calm and repose. The Society of Critical Care Medicine recommends using calming colours

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Chapter 4

An Effective Prescription for Healing

Listening with Undivided Attention

Ajay Shridhara Shetty

When in stillness, one listens with the heart. The ear is worth ten eyes.
– Zen Master Dae Gak[1]

Mr Sharma, who has been passing blood in the urine intermittently for the past six months, has come for a consultation with a urologist:

Mr Sharma: *Well, I don't know how to start, doctor. You know, for the past six months or so I've been feeling very weak. I get tired easily. I don't feel like my usual self –*

Doctor: *(Interrupting) Okay, but why have you come to see me? I'm a urologist. For these complaints, you'd be better off seeing a physician.*

Mr Sharma: *Well, I did, and they referred me to you because I'm losing blood through my urine.*

Doctor: *I see. Why didn't you tell me that before? (Very casually) Anyway, since when have you been passing blood in your urine?*

Mr Sharma: *Well, it happened for the first time about six months ago. In the middle of the night, I got up to pass urine, as I usually do, and suddenly I noticed that instead of urine, I was passing only blood. I got really worried and ….*

Doctor: *(Writing down notes, misses the nonverbal cue that the patient was anxious) I see … And how many days did this last?*

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Mr Sharma: *Well, I went to see a doctor the next morning. He gave me some medicines and the next day the bleeding stopped.*

Doctor: *Good … And since then you haven't had bleeding in the urine?*

Mr Sharma: *(Looking very worried) No. But the other doctor said that my urine tests show that I'm still passing blood in the urine.*

Doctor: *(Impatiently) Yes, yes, we will get to that. Tell me, when you passed blood the first time, did it hurt?*

Mr Sharma: *No, doctor. But –*

Doctor: *(Interrupting) Were there any clots?*

Mr Sharma: *Actually yes, I did pass a lot of clots along with the blood.*

Doctor: *(Raising eyebrows) That's not good …. Anyway, why did you wait for six months before you got yourself checked by a urologist?*

Mr Sharma: *(Uncomfortably) Well, doctor, the bleeding stopped the very next day and I thought I was fine. It's only now since I've been feeling weak that I decided to come for a check-up ….*

(The doctor is busy reading the patient's file and shaking his head while the patient watches.)

Mr Sharma: *Doctor, is it very serious?*

Doctor: *(Ignoring the patient's anxious query) Mr Sharma, your chart tells me that you're a chronic smoker and that you smoke five to six cigarettes a day.*

Mr Sharma: *(Diffidently) I've really cut down the number of cigarettes. I'm trying to quit altogether.*

Doctor: *(Shaking his head disapprovingly) Well, it's about time you did! Because I've gone through your reports and your test results show that you're still passing blood in the urine. And, considering your long smoking history, the first thing we have to rule out is bladder cancer.*

Mr Sharma: *(Shocked) Cancer? But – but – how can it be …?*

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Doctor: *That's the commonest cause of painless bleeding in the urine. We'll have to do an ultrasound to confirm it.*

Mr Sharma: *(Hopefully) Could it be something else, doctor?*

Doctor: *Frankly, cancer is at the top of the list of my suspicions. There could be other causes like an infection or a stone. But don't worry, whatever it is, we'll diagnose the problem and treat it.*

Now put yourself in the patient's shoes and evaluate this communication *purely from the listening perspective*. Do you feel that the patient was able to fully express all his concerns? Is this kind of scenario something you see or hear about commonly? Do you feel that the doctor was a good listener? If you are a doctor, do you talk to your patients in a similar fashion?

We will revisit the scenario above at the end of this chapter.

As a young intern being rotated through the Department of Medicine, I was delighted that I was posted in the second unit. This meant that I had a wonderful opportunity to work under one of my favourite professors. She was a brilliant academician and an exceptionally good teacher. Not only was she popular among us students, but also word in the hospital was that her popularity with the patients had to be seen to be believed. In the first few weeks of my internship, I saw with my own eyes this unique phenomenon of healing. I interviewed all my professor's patients, asking them, "What is it about this doctor that makes you want to come back to her?"

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The answers I got from the vast majority of the patients were a revelation. They taught me a lesson that five years of reading medical textbooks had not. The patients said, very simply: "She listens." My professor would become so engrossed in listening that often, even when auscultating a patient's chest, the earpiece of her stethoscope would not have moved from its normal resting position (behind the ears)!

Active listening

That was the day I realised that listening to patients' words and emotions was far more important than listening to the sounds of their hearts or breaths. My professor used listening as the single most effective way to establish trust and build a relationship with her patients. American psychologist Carl Rogers, who founded the humanistic school in modern psychology, coined the term *active listening* for this kind of listening.

The International Listening Association[2] defines listening as the "process of receiving, constructing meaning from and responding to spoken (verbal) and unspoken (nonverbal) messages." Although speaking skills are crucial for effective communication, they cannot substitute listening skills. Listening skills are concerned with the ability of a person to recognise and distinguish the relevance and relationship of spoken words.

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Chapter 5

Bridging the Gap

Removing Communication Barriers in Hospital Settings

Mercy Christudas
Glory Dennis
V. Kingsly R. Gnanadurai

Like stones rolling down hills, fair ideas reach their objectives despite all obstacles and barriers. It may be possible to speed or hinder them, but impossible to stop them.
– Jose Marti, 19th-century Cuban poet, writer, and nationalist leader[1]

Dr Singh is in the Intensive Care Unit at the patient's bedside. The patient's son, Jiten, wants to know about his father's condition. They are surrounded by noise – there is beeping from the monitors, whirring from the ventilator, and other noises within the ICU.

Jiten: *Doctor, why did this happen to my father?*

Doctor: *Because of hypertension.*

Jiten: *What?*

Doctor: *Your father's high blood pressure has caused his renal failure.*

Jiten: *Renal failure?*

Doctor: *His kidneys are affected and because of that, he is in pulmonary oedema. We need to consider dialysis.*

Jiten: *Pulmonary oedema … what's that? I don't understand! And dialysis? Please explain!*

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In the above-given scenario, it is evident that the communication from the doctor to the patient's relative is not very effective. There are various aspects that pose a barrier to effective communication. This chapter will explore the different barriers to communication that may exist in a healthcare setting.

Barriers to effective communication (Figure 1)

Communication has been defined as the "imparting or interchange of thoughts, opinions or information by speech, writing or signs."[2] It is relevant to note that communication is not just one individual expressing his or her thoughts or opinions, but an *exchange* of thoughts, opinions, or information. Second, this interchange or exchange can be in the form of speech, writing, or using signs. Although interpersonal exchange is of vital importance in healthcare communication (it is mainly through speech that rapport is established between patient and care provider), written communication comes into play soon, as does signage.

Healthcare Provider	Patient	Environment
• Spoken-language deficiencies • Use of multilingual formats • Excessive use of jargon • Unempathetic delivery of bad news • Frequent interruptions • Preoccupation with personal matters • Inefficiency or inexperience • Prejudice based on diagnosis	• Illiteracy/low literacy levels • Superstitious, religious, and cultural beliefs • Preconceived notions	• Physical • Long waiting periods • Lengthy admission and discharge procedures • Insufficient or poor signage • Lack of clear delegation of duties

Figure 1: *Barriers to effective communication.*

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As communication in health care occurs at multiple levels (individual, team, and organisation), in multiple formats (spoken, written, printed, and over public address systems), and in multiple contexts (common spaces, outpatient areas, general and private wards, intensive care units, etc.), the possible barriers are many. It has been identified in a study that the most common barrier between the healthcare provider and the patient is cultural difference.[3] Healthcare providers, thus, must make every effort to minimise the barriers in communication. These barriers may be grouped under three perspectives: healthcare providers, patients, and the environment.

Healthcare providers. From the perspective of healthcare providers, there are eight key areas in which communication barriers are experienced:

Spoken-language deficiencies. Language can be one of the most important barriers to effective communication. It is through a multilingual and improved communication capability that healthcare providers can establish a therapeutic or supportive relationship with a patient and win his or her trust and confidence. Healthcare professionals should, therefore, make serious attempts to learn the local language and use it in culturally sensitive ways. Ideally, healthcare providers should speak in the language preferred by the patient in order to establish effective communication pathways, as any miscommunication between patient and healthcare provider can lead to disastrous consequences.

Use of multilingual formats. Urban living makes it essential for the management of healthcare organisations to employ bilingual staff who can help as interpreters for patients.[4] Hospitals should, at all levels of the organisation, recruit, retain, and promote staff and leadership whose composition represents the demographic characteristics of the geographical service area. Signage and other patient-related information should, likewise, be displayed in the relevant multilingual formats. Institutions should ensure that the demographic data in the health file of a patient include his or her spoken and written languages.

Excessive use of jargon. Medical personnel often use terminology that is incomprehensible to patients. For example, telling a patient that he has suffered a myocardial infarction may go completely over his head because these terms are unfamiliar to a layperson. Simplifying and explaining such terms will go a long way in helping patients understand the essentials and ensuring that other barriers are not created. It will also minimise errors on the part of caregivers and make it easier for them to win the patient's trust.

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Unempathetic delivery of bad news. It is absolutely essential for healthcare providers to be empathetic when breaking bad news to patients or their families. The best way to do this is to look at the situation from the patient's point of view. It is only then that the healthcare provider can sincerely convey genuine care for the patient and his or her family. An empathetic approach includes giving a patient and his or her family the opportunity to communicate their thoughts, fears, and misgivings at an especially distressing occasion. Using gestures that bring a patient psychological comfort is also helpful.

Frequent interruptions. Very often, the visit of one healthcare provider to the patient's bedside overlaps with that of another healthcare provider. For example, while the dietician is counselling a patient about his or her diet, a nurse comes in and, without so much as a by-your-leave, gives the patient an injection and moves on to the next bed. For the patient, this can be dehumanising because the nurse has treated the patient's body as an object and inflicted pain on it; it is confusing and emotionally disturbing because the patient cannot possibly pay attention to both dietician and nurse simultaneously and will probably lose out on some important instructions or information being given. This can also irritate the dietician because of wasted time and a breakdown in communication between the dietician and the nurse, which can also reflect poorly on the hospital, as a result.

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Chapter 8

"Sorry" Works

The Disclosure of Medical Errors

Ajay Shridhara Shetty

To err is human, to forgive, divine.
– Alexander Pope

The practice of medicine is a human endeavour where most patients get better, go home, and resume their daily lives. But consider this:

A 25-year-old male undergoes an endoscopic procedure for the removal of kidney stones under general anaesthesia. The patient is anaesthetised and connected to a ventilator through an endotracheal tube. Subsequently, he is placed in a prone position (lying face down) for the purpose of the surgery. The surgery is uneventful but, towards the end, the anaesthetist notices that the patient's blood pressure and oxygen saturation are dropping. He asks the surgeon if there has been excessive bleeding during the surgery. When the surgeon replies in the negative, the anaesthetist immediately checks if the endotracheal tube is in position.

To his horror, he realises that the tube has slipped out and the dropping blood pressure and oxygen saturation are due to inadequate oxygenation of the lungs. The anaesthetist immediately repositions the tube and begins ventilation. But nobody is sure for how long the patient has been hypoxic. Thus, a young, apparently healthy patient, who was supposed to have a straightforward procedure to remove a kidney stone and go home in a few days, now may possibly suffer from hypoxic brain damage!

The patient is wheeled to the intensive care unit and kept on a ventilator. The entire team of doctors treating him, including the surgeon and the anaesthetist, is in shock. They have no idea how to break the news to the family. The surgeon refuses to do so because he feels it is entirely the

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anaesthetist's fault. The anaesthetist feels incapable of breaking the news to the family on his own as he has absolutely no experience in the disclosure of medical errors of this magnitude.

Medical errors, adverse events, and near-misses

The Institute of Medicine[1] defines medical errors, adverse events, and near-misses as follows:

Medical error. The failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning)

Adverse event. An injury that was caused by medical management and resulted in a measurable disability

Near-miss. An event that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention

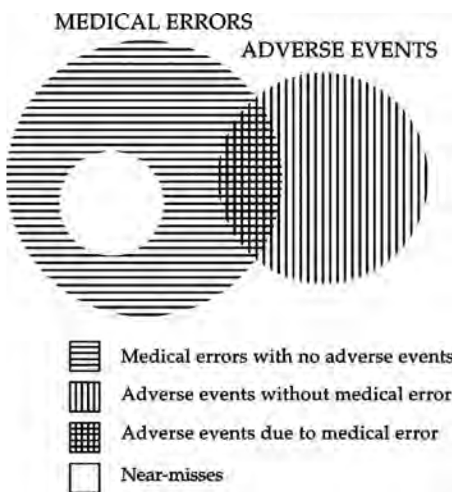

Figure 1: *Medical errors, adverse events, and near-misses.*

Most healthcare providers are aware that medical errors are not infrequent occurrences in everyday practice. Thankfully, the majority of patients who are victims of human error do not suffer serious adverse consequences. Some patients suffer adverse events that are nonpreventable, for example, the side effects of medical treatment. However, there are also patients who suffer from adverse events as a result of human errors that were completely preventable. This is depicted in the Venn diagram in Figure 1. This chapter deals with communication regarding medical errors with the latter group of patients.

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Now, consider the following example:

A patient complaining of severe abdominal pain is prescribed the antispasmodic Cyclopam. But the pharmacist is unable to read the physician's poor handwriting and has dispensed cyclophosphamide, an anticancer drug, instead. The nurse in the ward has not cross-checked the patient charts and ended up administering the latter drug intravenously, three times a day.

The administration of a wrong drug is a serious medical error. If the wrong drug administered does not have any side effects, then the incident falls in the category of *medical error with no adverse event*. However, if the patient starts bleeding in the urine (a very potent side effect of cyclophosphamide), then the incident would be known as an *adverse event due to medical error*. If the nurse-in-charge, realising that the drug is cyclophosphamide, and not Cyclopam, does not administer it, then the incident is a *near-miss*.

The code of medical ethics with regard to medical error disclosure

The ethics concerning medical error disclosure, laid down in the American Medical Association's code of medical ethics, are very clear: "It is a fundamental ethical requirement that physicians must at all times deal honestly and openly with their patients. Situations occasionally occur in which the patient suffers significant medical complications that may have resulted from the physician's mistake or judgement. In these situations, the physician is ethically required to inform the patients of all facts necessary to ensure understanding of what has occurred. Concern regarding legal liability which might result following truthful disclosures should not affect the physician's honesty with the patients."[2]

Why is medical error disclosure so difficult?

A disclosure of medical error is very challenging and demanding even for the most experienced physician. If you ask physicians what their concerns are with regard to medical error disclosure, then the first thing that they would say, in this day and age, is the fear of medical malpractice lawsuits. Now this does not mean that physicians are unconcerned about their patients' welfare. In fact, most physicians become highly concerned about their patients when an adverse event occurs and will do everything within their power to reverse or undo

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the damage caused. Other typical concerns of physicians in the context of medical error disclosure are the following:

- Fear of organisational sanctions or penalties
- Loss of credibility and self-esteem and a sense of professional inadequacy and failure
- Disruption of the therapeutic doctor–patient relationship
- Anguish and guilt for having let the patient down
- Damage to the reputation of colleagues among their patients and the adverse economic effects on the medical practice or specialisation as a whole

The threat of malpractice liability is a substantial barrier to a physician disclosing a medical error. A physician's disclosure of error and apology may be admitted as evidence in a malpractice trial.[3] The mental and emotional trauma that the physician would go through because of this could make the disclosure of errors an ordeal. Therefore, one might understand why most physicians automatically think about their heightened legal liability first and instantly quell thoughts of their duty to disclose.

As if the fear of a lawsuit were not enough, the physician has to deal with his or her own feelings of guilt, helplessness, remorse, and shattered self-confidence. All of these are bound up with intense

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Edited by **Dr Alexander Thomas**

Studies have shown that healthcare organisations incur a huge drain on their financial resources due to ineffective and inefficient communication. This book aims to increase awareness about the importance of communication in health care. Written by healthcare professionals and communication experts, it is replete with real-life scenarios that readers can identify with, and will serve as a guide to effective and efficient communication that affects the most important stakeholders in health care – the patient.

"I commend Dr Alex's efforts to bring awareness to the importance of communication in health care. The previous edition of this book has already made a huge impact on the healthcare landscape of our country. All healthcare practitioners must read this."

K. Kasturirangan
Former Chairman, National Education Policy Committee 2019

"Beautifully written, one learns as one reads invaluable insights into the functioning of the healthcare eco-system... it is a caring doctor and an empathetic environment that makes all the difference. A book that is very relevant to our times when violence against doctors is becoming disturbingly frequent."

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"As the saying goes – medicine is a science but the practice of medicine is an art... This book should serve as the Bible for all practicing doctors, especially in today's healthcare scenario."

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Dr B.N. Gangadhar
Director, National Institute of Mental Health and Neurosciences (NIMHANS)
Member, Board of Governors, Medical Council of India

"The third edition of this extremely insightful compilation is a comprehensive repository on healthcare communication... [and] makes for excellent reading. Highly recommended for the health profession's practitioners and educators alike!"

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