Talking the talk:

The keys to effective workplace communication

HIGHLIGHTS
• Describes the role of communication in determining a surgeon’s success
• Offers advice on contract negotiation
• Discusses how to effectively communicate with colleagues on surgical teams
• Provides tips for communicating with patients

Medical school is unlike any other type of graduate school. The first two years are filled with basic science and little patient interaction, so the opportunities to hone communication skills are diminished in comparison to those available to the average law or business student, for example. In fact, a medical school curriculum contains far fewer requirements for oral presentations, written assignments, and collaborative team efforts.

Furthermore, the nature of medicine—where a person’s life is in the physician’s hands—complicates matters. For example, a lawyer may decline a case if it is likely to be unwinnable. When a venture capitalist or a businessperson fails to see potential in a startup or investment, he or she simply puts money into the development of a different product. But when a patient comes through the hospital doors, a physician must provide care to that individual. In each patient encounter, communication is necessary, starting from the initial history and physical to follow-up visits. In The 7 Habits of Highly Effective People, Stephen Covey writes, “Communication is the most important skill in life.” Regardless of profession, this ability is the cornerstone of success.

General surgery education is changing, and residency programs are placing greater emphasis on trainee assessment. Among the most challenging
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Competencies to evaluate are surgical residents’ interpersonal and communication skills. The importance of communication in medicine has been emphasized since the pre-scientific era and is described strikingly well in Hippocrates’ aphorism: “Life is short, and Art long; the crisis fleeting; experience perilous; and decision difficult. The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate.”

In this article, the authors discuss how to develop a successful career track by learning how to negotiate contracts with superiors, how to effectively communicate with multidisciplinary teams or co-residents, and, perhaps most importantly, how to talk with patients. These basic guidelines should prove useful to surgical residents seeking a successful career.

Contract negotiation and a successful career track

In a recent study of 43 surgical residents entering practice, less than a quarter of those surveyed said they feel confident in their understanding of practice management and leadership. It is admittedly difficult, especially during the rigors of training, for a resident to figure out which questions to ask to determine whether a practice meets his or her needs. How is a newly minted surgeon able to undertake the Herculean task of selecting a practice, negotiating a contract, and making his or her own way in a large group or hospital employment setting? The appropriate timing, transparency, and tone when communicating with mentors, family, and potential partners and employers are essential to starting a successful career.

Timing

Before looking for a practice, a surgeon should make several decisions with regard to the practice environment in which he or she would like to work beyond choosing between private practice and academia. Residents should ask themselves what type of practice they are interested in (solo, small group, large group, employment by a health maintenance organization [HMO] or a hospital), determine the potential for advancement, and ascertain whether the location is satisfactory, to name a few important considerations.

A recent article indicates that approximately 75 percent of physicians (n=2,813) are employed by large groups, hospitals, or health management organizations. In fact, a smaller group or solo practice may ultimately be absorbed by one of these larger entities—a possibility that the new surgeon should consider before joining one of these practice settings. It also is important to discuss these options with those who may be affected by your decision, such as one’s spouse or family, to determine what setting would be workable for all concerned. Practical concerns include location, mobility, call schedule, vacation, and so on. Contacting a mentor at the beginning of your search may streamline this process and help prioritize non-negotiable expectations versus factors that have greater flexibility.

After the physician determines the type of practice desired, there will often be telephone discussions with a specific practice to gather additional information. This will usually be followed by a letter of intent from the practice, which describes in writing what was discussed. This document is not legally binding. At this point, the surgeons should contact a contract lawyer for advice. Next, an offer letter is usually sent; this document is a binding contract that may limit the surgeon’s options at a later date. This letter provides surgeons with the opportunity to seek more information before negotiating the final contract.

Transparency

It is important to be transparent with the practice when developing a contract. The contract should contain details regarding the term length of the contract, automatic renewal of the contract, call schedule, benefits, retirement planning, vacation, bonus and productivity incentives, tail coverage, disability coverage, non-compete clauses, contract termination, and so on. The surgeon should decide what he or she can and cannot live with, and then communicate these items to the contract lawyer, who can offer advice on what
contract terms to alter, how to phrase the terms, and help to identify red flags.

Likewise, you should expect transparency and clarity from the practice with which you are negotiating. Be sure to read the entire contract and ask detailed questions if you have any concerns. If you find a provision objectionable, ask the organization to remove it. Think twice before agreeing to terms that sound suspicious, even if the practice insists that they will never be enforced. Once the surgeon has signed the contract, he or she will have no recourse if there is a disagreement.

Ask for copies of corporate bylaws and partnership agreements, as these documents may contain elements that will affect your practice. For example, a partnership agreement may allow more established partners to take call less frequently or have more vacation, resulting in an increased workload for newer surgeons. Also, the financial documents of the group and hospital should be reviewed, as their finances may affect your future earning potential.

It is important that the surgeon fully understand the leadership structure of the organization. Physician satisfaction in the workplace is heavily influenced by the efficiency of the immediate work environment, the schedule flexibility and autonomy granted by the leadership, and the workload requirements.

Additionally, you may be expected to standardize aspects of your practice, such as referral patterns. Be aware that compensation may be different in an integrated practice than in a typical group practice, so educate yourself on the exact stipulations of the compensation plan. Success in a large organization is driven more by collaboration than the "deficit-based" thinking that rules the clinical setting. If the institution's leaders value collaboration, they will more likely listen to your concerns, and you may be better able to make beneficial changes once you begin your practice.

**Tone**

Tone refers to how you present yourself to potential employers or group partners. Everyone appreciates someone who is pleasant, hard-working, and has good decision-making ability, so avoid exuding “the surgical personality” in your negotiations. Keep an amiable tone at all times, especially when discussing the finer points of the contract or when discussing a point in the contract with which you don’t agree. How you interact initially will set the stage for interactions later in your career.

**Effective communication with colleagues**

Communication breakdowns between the provider and the patient, the provider and the family members, or both are reported as the second-most common cause of inpatient surgical errors resulting in patient injury. It is a well-documented fact that limiting communication breakdowns could substantially decrease complications, delays in care, and overall morbidity of the surgical patient. Effective communication increases patient satisfaction and improves health outcomes, while poor communication is linked to patient complaints and liability claims.

One of the most important skills for effective communication is the ability to manage one’s own emotions and to perceive the emotions of others—also known as emotional intelligence. The surgeon’s ability to identify and manage his or her emotions as well as the ability to understand the emotions of patients, family members, and colleagues is fundamental to the successful provision of optimal patient care. Finding ways to train surgeons and residents with the aim of improving their emotional intelligence is a growing field of research in medical education, although its value has been demonstrated in the business community for many years.

Interpersonal attributes such as trust are known to contribute to the success of interpersonal communication between surgeons, both in the emergent and nonemergent hospital setting. Building a foundation of trustworthiness in interpersonal relationships with colleagues can be a complex, laborious process. Seniority and a proven track record are often synonymous with increased trust in the surgical setting.
The surgeon’s ability to exhibit effective communication skills in specific circumstances is crucial. For example, knowing how to discuss operative risks and benefits, obtain informed consent, and convey bad news are all important elements of patient care communication. But the ability to modify communication strategies and personalize the message for a co-resident, attending, patient, or patient’s family is equally important for success in delivering the best possible surgical care.

Ineffective communication between surgery residents and attendings typically occurs when the resident fears losing autonomy or being a bother, revealing a knowledge gap, and creating misunderstandings. Although there is a proven link between miscommunication and medical errors, few surgical residency programs have formal communication training or specific guidelines for the residents about when, how, and why to communicate with their attendings. This lack of guidance could be detrimental to patient care, especially during the intern year when most surgical residents teach themselves through a time-consuming “trial and error” development of their communication skills.

Identification of communication mishaps and understanding why they occurred is the first step in dealing with medical errors resulting from ineffective communication between patients and surgeons. One effective way to deal with communication breakdowns is the implementation of a policy-based intervention across different hospitals such as the one organized by the Risk Management Foundation of the Harvard Medical Institutions in 2005. This collaboration brought together the chiefs of surgery at Brigham and Women’s Hospital, Massachusetts General Hospital, Beth Israel Deaconess Medical Center, and Children’s Hospital, Boston, who all endorsed three communication standards that had been previously proven to significantly diminish patient harm because of gaps in communication. Indeed, this program was deemed to be beneficial as significant changes in patient management were noted in 33 percent of the cases in which trainees and attendings adhered to the enforced communication strategies.

Communication breakdowns may lead to medical errors, and medical errors may lead to legal claims. The University of Michigan Health System (UMHS), Ann Arbor, designed and implemented a comprehensive medical error disclosure with offer program in 2001. This program was based on three main principles:

- Compensate patients quickly and fairly when inappropriate medical care caused harm
- Support caregivers and the hospital vigorously when patient care was appropriate
- Reduce patient harm (and therefore claims) by learning from previous mistakes

### TABLE 1. THE CALMER TECHNIQUE

<table>
<thead>
<tr>
<th>Catalyst for change</th>
<th>Acknowledge what can and cannot be controlled. Identify the patient’s current stage of change.</th>
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<tbody>
<tr>
<td>Alter thoughts to change feelings</td>
<td>Acknowledge feelings toward the patient and assess the effect on the relationships. Ask: “What can I tell myself about this situation to make me feel less angry or frustrated?”</td>
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<td>Listen and then make a diagnosis</td>
<td>The physician is better equipped to listen without bias after completing the above two steps.</td>
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<tr>
<td>Make an agreement</td>
<td>Explicitly agree to continue to treat the patient and to work on the problem as agreed upon.</td>
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<tr>
<td>Education and follow up</td>
<td>Give an achievable task based on the patient’s stage of change and schedule structured follow-up.</td>
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<tr>
<td>Reach out and discuss your feelings</td>
<td>Reflect on how you feel after the patient encounter and reach out to other physicians to engage in discussion and for support.</td>
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The UMHS medical error disclosure program managed to decrease the number of lawsuits and liability costs and significantly shortened the time required for resolution of a claim.15

In 2014, Atul Gawande, MD, MPH, FACS, delivered four British Broadcasting Corporation Reith Lectures on The Future of Medicine.21 In one lecture, Dr. Gawande noted that there are two primary reasons why surgeons fail. The first one is ignorance—the limited understanding of the conditions that apply to any given problem. The second reason is ineptitude—having the knowledge but failing to apply it correctly.21 A blended mix of formal education for surgical residents to improve their communication skills and implementation of surgical checklists is the recipe for a brighter future of surgery in which optimal communication and reduced errors are the norm in the surgical patient care.

Communicating with the difficult patient
The difficult patient may pose a challenge even for the most experienced and composed physician. In the adult primary care setting, 15 percent to 30 percent of patient encounters are labeled as difficult, according to the physician.22,23 (It should be noted that most of the literature on difficult patients comes from the primary care sector.) Although the day-to-day practices of surgical and primary care differ, the principles of patient communication apply to all specialties. The patient encounter is shaped by the behavior of the patient, the response of the physician, and the situational factors. Each of these factors must be recognized and addressed to optimize communication.

Earlier studies have tried to characterize difficult patients and suggested these individuals are more likely to have multiple poorly defined symptoms, personality or psychiatric disorders, and subclinical behavior traits, and they are often older, recently widowed or divorced, and of lower socioeconomic status. The difficult patient also is likely to be non-adherent to the treatment plan. In a 1978 New England Journal of Medicine article, James E. Groves MD, further classified difficult patients as belonging to one or more of four subgroups: (1) dependent clingers, (2) entitled demanders, (3) manipulative help-rejecters, and (4) self-destructive deniers.24 The article recommends screening for psychiatric diagnoses or a history of physical or substance abuse and then approaching the difficult patient with motivational interviewing and patient-centered communication through which symptoms are validated and boundaries are set.

Perhaps most importantly, the physician should identify the subtype of difficult patient and tailor the encounter accordingly. Dependent clingers exhibit neediness and evoke aversion from the physician. The physician must be firm but tactful and set limits on the patient’s expectations. The entitled demanders often threaten the physician with punishment, mainly lawsuits, and evoke a counterattack response. The physician should acknowledge the patient’s right to receive excellent care and redirect the entitlement into a partnership. Manipulative help-rejecters are often smugly satisfied when the prescribed treatment is ineffective and have a pathologic dependency on the patient-physician relationship, evoking feelings of depression, guilt, or inadequacy in the physician. The best approach here is to commiserate with the patient.
The patient encounter is shaped by the behavior of the patient, the response of the physician, and the situational factors. Each of these must be recognized and addressed in order to optimize communication.

and assure him or her that successful treatment of the condition will not result in loss of the patient-physician relationship. The self-destructive deniers evoke all of the feelings of the other subtypes in addition to malice. These patients require decreasing expectations that perfect care will be delivered and may require a psychiatric consultation. In the end, how the physician feels about the patient is of little importance; what matters is how he or she behaves toward the patient.

The physician plays a role of equal importance to the patient in difficult encounters. The physician may have a negative bias toward a specific disease, have poor communication skills, lack experience, feel overworked, or suffer from personal health issues. Although most literature on the difficult encounter focuses on the difficult patient, one study attempted to characterize the difficult physician. A total of 1,391 family medicine, internal medicine, and internal medicine subspecialists completed the Physician Worklife Survey regarding personal and practice characteristics and work satisfaction. On multivariable analysis, high work frustration was independently associated with age younger than 40 years old, higher stress levels, subspecialty practice, and higher number of patients with psychosocial or substance abuse disorders. The number of hours worked greater than 55 hours per week had borderline significance.22 Another study showed female physicians who had lower scores on the physician satisfaction scale and were less satisfied after difficult encounters than their male counterparts.25 To better navigate difficult encounters, physicians must practice self-reflection and recognize bias and should seek support from trusted colleagues or Balint groups, which focus on the clinician-patient relationship.

Situational factors also must be considered. Time is a precious resource in all aspects of medicine, and time limits can compromise the ability to communicate effectively. The physician should acknowledge time delays and plan for additional counseling time with difficult patients. The physician also should maximize the time available by sitting at the patient’s level, maintaining eye contact, and conducting the encounter with a

REFERENCES

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relaxed demeanor. Complex social issues and limited resources may also put a strain on the encounter and may require the involvement of a social worker.

Various communication tools have been developed to guide the physician through difficult patient encounters. The CALMER strategy is a six-step process to serenity when dealing with difficult patients and combines elements from Prochaska and DiClemente’s Stages of Change model, Shahady’s Rule of Five, and Gillette’s Practical Approach for Managing Problem Patients, as well as principles of cognitive-behavioral therapy (see Table 1, page 19). The BREATHE OUT approach is a similar tool and was developed for a randomized controlled trial at six family medicine clinics in urban, suburban, and rural locations (see Table 2, page 20). A total of 57 clinicians, including physicians, physician assistants, nurse practitioners, and residents, completed the Physician Satisfaction Scale (PSS) after implementing the BREATHE OUT technique, and those who were instructed in the use of BREATHE OUT had improved PSS scores after difficult encounters (p=0.02). Use of the tool took less than three minutes.

Conclusion
Effective communication is a key skill for successful surgeons and the delivery of high-quality patient care. The ability to communicate with your superiors is equally important as the ability to communicate with your peers and patients. Although these interpersonal skills are difficult to measure and standardize, the author’s anticipate that these guidelines and techniques will prove useful in each of those encounters.

REFERENCES (CONTINUED)