Commentary

The mind of an academic, the voice of a patient: My field experience with safe communication

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There is nothing more terrifying than losing control. Not over a task at work – but over one's own body. When the body just sinks to the ground and stops working. When your brain stops controlling your movement and speech, and you are left as an inanimate pile on the floor. This is how you see yourself from a cognitive distance, hoping only that no one will see you in this condition.

As a communication scientist, I am used to running controlled experiments in healthcare settings. In my research, I was able to control how people communicate and measure what effects this would have on patient safety.

Now, my control over this was gone as well. As a consequence of the weakness of my brain and body, I was exposed to weaknesses in our healthcare system. I found myself in a stroke unit, in the kind of healthcare setting I had studied for years using scientific methods. As a patient safety academic, I was now participating in an unexpected field study in the skin of a patient.

In this commentary on handoffs and patient involvement, I will highlight critical challenges in communication and patient safety that I observed during this trial – with the mind of an academic, and the voice of a patient.

On my first morning in the stroke unit, the physicians on duty overnight conducted their handoff with the daytime physicians at the foot of my bed. Four physicians were involved in the conversation. The physician responsible for "delivering" the relevant information to the incoming physicians held a folder in front of her chest and a pen in her hand. The incoming physicians also held a piece of paper with a pen in their hands and took notes. There was hardly any eye contact between them during this critical conversation, everyone focused on their note-taking.

The physicians were strict about following some predetermined SBAR[1]-like handoff structure. It was evident they felt that getting distracted would destroy the handoff, because they would lose their train of thought – and along with it, the confidence they had put in the procedure to cover all relevant information. Their thought processes were guided solely by the content categories of the SBAR scheme.

The only interaction with me, the patient, was a quick "good morning" when they entered the room. From there, they proceeded with their SBAR-handoff. While I was allowed to listen, I was not allowed to interrupt. I suppose this advance of conducting the handoff in front of me rather than in the hallway was what they considered to be patient involvement.

The physicians probably knew my professional background, as they seemed a bit tense about conducting the handoff in front of me. It was apparent that they tried to do it particularly well, i.e. to cover all information within each category of the SBAR scheme. It felt like a massive quantity-of-information checklist.

The problem, though, was that critical information had changed from the day before until today. When I had checked into the ER the previous night, I reported that my right arm felt about 5% numb. Already then, the ER physician had reported to the neurologist on call that my right arm had been hurting me. I corrected the physician at that time, stating that my arm never hurt me, but that it merely felt a bit numb (the degree of which I estimated again at about 5%). The physician had nodded at me quickly in

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response and then continued reporting to the neurologist. No note was taken of my correction. Now, this morning, the handing off physician stated that I had reported a *tickling* sensation in my right arm. So, between yesterday and today, there were three different descriptions of my right arm sensation being handed off between the various physicians caring for my critical condition.

We have written about the danger of this game of "telephone" in our books.[2,3] Therefore, I was familiar with this challenge and felt confident that I could correct this information more effectively, by interrupting the physicians briefly to make sure that the sensation was recorded correctly now.

However, when I tried to gently interrupt to correct this information, the physicians appeared visibly challenged. The female physician who was handing off the information stopped me immediately by raising her hand up like a police officer stopping a car. It was evident that she would lose her train of thought if I interrupted her now. To her nonverbal hand-raising gesture, she added the following verbal qualifier: "We need to get through this information first, otherwise things get confusing. You can comment later after we are done."

Several more pieces of misinformation followed during the same handoff. I wished I had a piece of paper and pen to take notes on all the information I needed to correct, but I didn't. The physician who requested that I hold my comments until later must have forgotten that I was an acute stroke patient, for whom keeping information in memory was difficult. Taking notes in that moment would have helped me recall later what I needed to correct, for the accuracy and perhaps safety of my care.

When the SBAR-handoff finally came to an end, the physicians were now visibly under time pressure to get to the next patient. It was clear they would be annoyed if I added more information to their already time-consuming handoff, which they had perceived as sufficient from a clinical standpoint. It was clear that the value of what I would have to add was inferior to what they had already asserted.

The system reform they were implementing was that I, as a patient, was invited to listen to the handoff. But I was not allowed to participate. The healthcare team's nonverbal communication conveyed that I was the patient and had nothing to contribute to what needed to be done now in medical terms. I was not invited to engage in the sense-making process, which would have been crucial for effective communication. Their communication was not about establishing a shared understanding among all of us in the room. The sense-making was reserved for one camp of participants: I was the care recipient, not the care provider, and thus the object of the medical challenge, not part of the sense-making process.

Ironically, I suddenly found myself in my own book, in one of the dozens of patient safety cases we had studied, some of which had resulted in severe adverse events due to precisely this communication that is intended to promote safety, but which in fact impedes it. What was happening here, with the regimented use of SBAR, had nothing to do with safe communication. The providers followed the protocol. They became human automatons, controlled by a tool to structure communication. But they failed to communicate. A partner was missing from the communication.

There are two take-home messages I would like to share in response to this field experience:

Take-home 1: SBAR is a tool to structure the content of handoff communication. It *does not* constitute or replace communication skills. Skills, like the ones we defined as "safe communication" in our scientific work,[2–4] are a prerequisite for mnemonic tools like SBAR to work safely and effectively.

Take-home 2: Patient involvement *does not* mean that the patient may only listen, even if the primary communication is between two clinicians. Patient involvement draws on all care participants (including patients and care companions) to achieve a shared understanding among all involved, as a basis for safe, high-quality care provision.

It was not only the stroke that knocked me off my feet. What saddened me most was the fact that I, an informed patient, a patient safety academic, and the intellectual mother of the "safe communication" framework, had no chance to correct unsafe communication in the process that threatened the safety of my own care. This leaves me wondering. Also, the experience of this communication failure from the skin of a patient was overwhelming. I felt helplessly exposed, with inaccurate information about my condition circulating among physicians and me being unable to correct it, because people were too occupied with their own communication protocol to listen to me. I felt myself wondering: if they do not even get straight such a simple thing as the sensation of my right arm – despite multiple corrections – how could they understand the much more complex facets of my condition? Which only I can tell them? Which they will not understand from communicating among themselves?

Of course, we must activate patients. But we also have to allow them to be active. Of course, we must train clinicians to have safe communication skills. But more than that, clinicians need to be willing and able to be flexible in their roles in healthcare – to get everyone on the same stage, where humans meet with humans. Where all voices are heard. Where the brain of clinicians merges with the voice of the patient, to become a complementary whole.

This is the only way care can be safe – on the foundation of a shared understanding.

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