Understanding Communication Barriers Between Providers and Communication Vulnerable Patients (Not Related to Language or Culture)

Health care delivery flaws occur today regardless of language and cultural barriers and arise across the entire continuum of care. People who are unable to use their natural speech, those who have limited speech due to surgery or other circumstances, those with brain injuries, the elderly, young children, etc. are far too often victimized by inadequate patient-provider communications. Even more troubling is the known fact that the vast majority of medical professionals have not had the requisite training to communicate effectively with their patients. As a result of these compounding factors, preventable adverse events in health care settings are often a function of poor patient-provider communication and the underutilization of inexpensive, low-tech tools and strategies.

The articles below suggest a variety of interrelated factors that contribute to poor communication in health care settings. Many propose that the main factors that lead to preventable adverse events in health care settings are communication problems and poor clinical management. Others suggest that obstacles to effective communication include the vast gap between the healthcare world and that of the average patient, low health literacy, and low standard literacy rates. Another article attributes preventable adverse events in health care settings to cognitive doctor mistakes, which are classified into three categories: (1) anchoring, or making snap judgments based on initial findings; (2) “availability,” or assuming that recent experiences can explain new situations; (3) “attribution,” or attributing symptoms to a preconceived stereotype about the patient.

In addition to poor management and cognitive doctor mistakes, the underutilization of alternative and augmentative communication tools contributes to the incidence of preventable adverse events in health care settings. For example, one article describes a study conducted by a group of doctors and nurses to determine the level of frustration patients experience when trying to communicate during mechanical ventilation, their level of frustration with the use of a communication board, and their perceptions of the appropriate format and content of this communication tool. Sixty-nine percent of patients in the study said that they would have experienced less frustration during mechanical ventilation if they had used a communication board.

Medical miscommunications as a result of these factors increase the incidence of adverse events and serious errors in critical care settings. In a one-year observational study using direct continuous observation throughout the time period, participating doctors studied 391 patients and found 120 adverse events in 79 of them, including
45% preventable and 55% non-preventable adverse events, as well as 223 serious errors. Among the adverse events calculated, 13% were life-threatening or fatal. They found that most serious medical errors occurred during the ordering or treatment delivery processes, especially when giving patients medicine (61%). A similar study by Groopman suggests that fifteen percent of all patients are misdiagnosed.

The following articles provide additional information regarding the nature of communication barriers not related to language or culture:

www.elsevier.com/locate/apnr

The article describes a study conducted by a group of doctors and nurses to determine the level of frustration patients experience when trying to communicate during mechanical ventilation, their level of frustration with the use of a communication board, and their perceptions of the appropriate format and content of this communication tool. Sixty-nine percent of patients in the study said that they would have experienced less frustration during mechanical ventilation if they had used a communication board. The same patients identified specific characteristics the communication board should exhibit to facilitate communication with health care providers.

http://www.jfponline.com/Pages.asp?AID=1344&issue=November%202002&UID=

This study analyzes published medical data and literature to classify and describe preventable adverse events and process errors in primary care settings. The authors categorize preventable adverse events as diagnostic, treatment, and preventive care incidents; they also classify process errors into four major categories: clinician factors, communication factors, administration factors, and blunt end factors (insurance and government regulation errors). The study illustrates the kinds of preventable errors that occur in primary medical care settings (such as misdiagnosis or administering an incorrect dose) and explains why they occur (such as failure of clinician–patient communication).

3. Rothschild, Jeffrey M., Landrigan, Christopher P., Cronin, John W., Kaushal, Rainu, Lockley, Steven W., Burdick, Elisabeth, Stone, Peter H., Lilly, Craig M., Katz,
A group of doctors report on their study about the nature and incidence of adverse events and serious errors in critical care settings. They conducted a one-year observational study using direct continuous observation throughout the time period. The doctors studied 391 patients and found 120 adverse events in 79 of them, including 45% preventable and 55% non-preventable adverse events, as well as 223 serious errors. Among the adverse events calculated, 13% were life-threatening or fatal. They found that most serious medical errors occurred during the ordering or treatment delivery processes, especially when giving patients medicine (61%).


A team of doctors undertook a research project to determine whether communication problems are linked to an increased risk of preventable adverse events in medical settings. The authors discuss the context of the problem in the introduction, stating that language barriers and communication disorders decrease the quality of care patients receive, and 5-10% of the general population suffers from such disorders. The authors delineate their research methods, which include a random sample of 2,355 hospitalized patients’ charts with which they assess the cause and preventability of adverse events. Their results show that patients involved in adverse events were significantly more likely than those not involved in such events to have a communication problem or psychiatric disorder.


This newsletter is based on health care recommendations from the executive director for strategic initiatives for the Joint Commission on Accreditation of Healthcare Organizations, Dr. Richard K. Croteau. Dr. Croteau believes that improving
communication in health care settings would have the greatest impact on patient safety, and he encourages health care delivery organizations to work toward this end. JCAHO provides a short list of recommendations to reduce medical errors, focusing on delays in treatment. Dr. Croteau says that communication errors can occur orally, electronically, and in writing, and he suggests limiting verbal orders whenever possible.


Dr. Allan Frankel uses a study conducted by Bartlett and colleagues to highlight major health care delivery flaws that occur today, regardless of disabilities or communication limitations. The two main factors that lead to preventable adverse events in health care settings are communication problems and poor clinical managements. The author discusses a solution to reducing communication barriers involving a communication framework that ensures patients are aware of how to properly care for themselves. Dr. Frankel advises that decreasing the risk of preventable adverse events will also require effective standardization and simplification of care. The article concludes with a brief comparison of health care systems in different world regions.


The article commences with statistics demonstrating the gravity of medical misdiagnosis, stating that around fifteen percent of all patients are misdiagnosed. According to the author, most medical diagnoses are due to mistakes in the minds of doctors. There are three kinds of cognitive mistakes that lead doctors to misdiagnose their patients. The first is anchoring, or making snap judgments based on initial findings; the second is availability, or assuming that recent experiences can explain new situations; the third is attribution, or attributing symptoms to a preconceived stereotype about the patient. The author provides a list of three questions patients can ask doctors to reduce the risk of misdiagnosis.

The article summarizes a study funded by Forth Valley, Ayrshire and Arran Primary Care NHS Trusts in the U.K. that highlights the experiences of eight patients with Complex Communication Needs (CCN) in an acute hospital ward. The article discusses the aims, methodology, and results of the study, the latter of which involves feedback from patients with CCN, hospital staff members, and caregivers. The study focuses on problems that occur when people with CCN are hospitalized, such as patients’ inability to describe pain and a lack of available communication resources. The article also makes recommendations for improving communication among patients, hospital staff, and caregivers in healthcare settings.


This article discusses how a majority of emergency room patients are sent home without understanding the treatment they received or how to care for themselves once they are home. When patients are not properly prepared for self-care, they are more likely to be readmitted to the hospital or become more seriously ill. Hospitals are often pressured to serve many patients a day, and caregivers tend to devote little time explaining diagnoses, treatments, and self-care instructions to patients. Dr. Eric Coleman, director of the Care Transitions Program at the University of Colorado, claims that nearly half of all patients are considered to lack the ability to process and understand basic health information they need to make decisions. This, coupled with many doctors’ failure to communicate effectively with patients, leads to misunderstandings and subsequent medical errors.


This article describes a serious medical error in which a middle-aged man died after surgery because no one turned his implantable cardioverter defibrillator (ICD) back on after the procedure. After several unsuccessful attempts to resuscitate him, doctors deemed the cause of death to be ventricular fibrillation. No one was unable to immediately detect and treat the man’s condition because of a previous failure to reactivate his ICD after surgery. The authors list and describe several circumstances under which implanted electronic devices need to be turned off, followed by suggestions about how to promote public health and safety when this is the case. One suggestion involves maintaining clear communication with all professional staff members who treat the patient about the type of device being deactivated, as well as
its status.


The United States government conducted a national survey in which a random sample of patients treated at more than 2,500 hospitals from October 2006 to June 2007 completed questionnaires about hospitals and their staff and cleanliness. Nationwide, 67 percent of patients said they would recommend the hospital at which they were treated to friends and relatives. However, many patients complained that they were not treated with respect by caregivers, did not receive adequate pain medication after surgery, and did not understand the instructions they received for home care once they left the hospital. Dr. Carolyn M. Clancy, director of the Agency for Healthcare Research and Quality, claimed that poor communication was a major source of medical errors, encouraging doctors and nurses to listen more carefully to their patients.

http://www3.interscience.wiley.com/journal/118983317/abstract?CRETRY=1&SRETRY=0

The authors of this study interviewed twenty nurses from four hospitals in Sydney, Australia who had experience communicating with patients with severe communication impairment. The aim of the study was to find out about the successes and obstacles nurses encountered during patient-nurse communication to better understand how to train nurses to effectively interact with non-verbal patients. In half of the interview responses, nurses identified a lack of access to appropriate augmentative and alternative communication (AAC) strategies as a major problem in interacting with patients. The lack of communication systems in hospital settings increased the amount of time and effort spent on communication, leading to considerable frustration for both nurses and patients.

http://www.aacnclinicalissues.com/pt/re/aacn/abstract.00044067-200105000-00008.htm;jsessionid=JDpXp1LVND2YYzMXBYqITdvZpdF2nQqpdvGpNvh32jX8cF786NMT!-348297060!181195629!8091!-1
The author discusses the difficulties and stresses mechanically ventilated patients experience in the intensive care unit (ICU) when trying to communicate with doctors and nurses. Critical care nurses rarely receive training in effective communication with non-verbal patients, and most are unfamiliar with augmentative communication methods. Dr. Happ’s article explores the existing research.