The 5 most common mistakes in hospital communication

What you should pay attention to, tips and tricks for practice.

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"90% of problems at work are due to interpersonal differences, not differences on substantive issues."

Have you ever felt that you treated your counterpart exactly as you would like to be treated and addressed? But instead of being appreciated, the mood only worsened and the situation escalated.

That's because the so-called "golden rule of communication", to treat the other person as you would like to be treated, is rubbish. Here you will learn why this is so and what you can do instead, as well as other useful strategies that will make it easier for you to deal with others.

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7 years of experience in nursing

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Has been travelling internationally for over 10 years as a trainer for executives in medicine and other high-risk industries.

Full CV here. Trainer profile here.

You interrupt too early

Yes, you do. Not you, of course, you can do it better. But for now, listen to me. On average, it takes eleven seconds for a doctor to interrupt his patient (Singh Ospina et al., 2019). In the study, doctors were even observed interrupting the patient after only three (!) seconds. Yes, we have little time. However, if we don't know why the patient is coming to us - and we won't know if we don't listen to them - then the conversation will take *longer*.

True, the sooner a doctor interrupts a patient because he thinks he knows what the patient is getting at, the longer the conversation lasts and the less the doctor ultimately knows about what the patient wants from him. Because in many cases, the first complaint made is not the main one the patient comes to the doctor for. Is that surprising? That one doesn't open up fully at first contact? Not really. In most countries, people beat around the bush before they talk about haemorrhoids. In the same study, it was found that only 36% of the doctors consulted found out the real reason for the visit. Not even half of the doctors knew at the end why the patient had really come to them, and treated or prescribed something for a minor problem. If the patient gets around to voicing their main concern in the first few seconds, they are interrupted *even more quickly,* as the doctor then immediately jumps on the symptom.

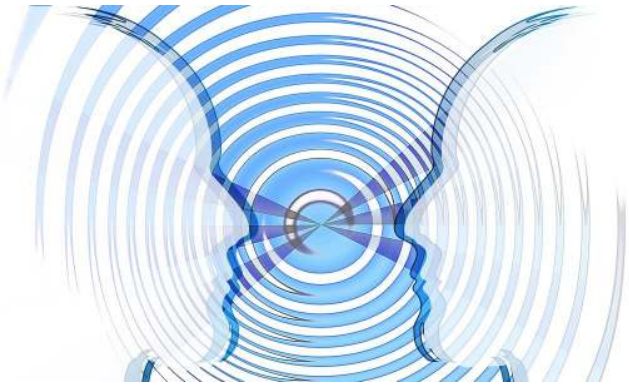
Studies of this kind have been done several times over the last thirty years and, unsurprisingly, the time to interruption has continued to decrease. This is consistent with my personal experience, as a doctor and as a patient, and the experience of everyone I have spoken to about this. A doctor who gives the impression that he will take time for the patient is usually not a doctor but an alternative practitioner. This is because they are paid for a detailed anamnesis interview.

So what should we do? Should we change something? Even today, the medical history is the most crucial diagnostic tool we have as a doctor. A good history gives us the clues as to which diagnostic tests and methods we should use. This in turn also saves costs. Willam Osller's guiding principle "Just listen to your patient, he is telling you the diagnosis." (Sturdy, 2000) was confirmed by a study that showed that in 80% of cases the diagnosis was made purely by history (Hampton et al., 1975). That was over 45 years ago and lo and behold, not much has changed to this day. For example, the best way to detect clinically relevant coagulation disorders remains the medical history. Why anaesthetists can give a central regional anaesthesia without asking for a laboratory with Quick, PPT, INR, platelets and fibrinogen if the (bleeding) anamnesis is unremarkable (Schlimp et al., n.d.). You have to have queried them for that. By the way, the most common relevant coagulation disorder, the Von Willebrand syndrome, is not detected by our common tests mentioned above. But it can be detected by a conspicuous medical history.Apart from the fact that it makes sense to find out why a patient goes to the doctor, and it is also much more pleasant for both sides not to have a rushed conversation, there is another reason to let the other person finish. And that is for precisely those who now think, I don't have time for that. Because: If I let the other person finish at the beginning, the conversation will be shorter overall! As a side effect, patient satisfaction with the attending doctor increases.

Conclusion: Let the patient (or the colleague, not to mention your partner) finish, or at least do not interrupt for the first 30 seconds. This

- saves time,
- saves money,
- helps with the correct diagnosis and treatment and
- increases the satisfaction of both parties.

Too little compassion is shown



What is the point of compassion at all? The doctor should be professionally qualified and thus help the patient. Empathy or sentimentality does not occur in a guideline-based therapy and is rather a hindrance in the first place when one has to act quickly and decide objectively in emergencies, isn't it? The short answer is: that is wrong.

- Compassion has a measurable positive effect on the patient's therapy outcome.
- Compassion has a measurable effect on *cost reduction*, *efficiency* and *higher quality of care.*
- Compassion has a measurable effect on increasing the *resilience of* doctors and contributes measurably to burnout prevention.

That was often the word "measurable". Because it is important to make clear that compassion is not a "nice to have". Compassion is not a dessert after the main course of first-class medical care, but medical care with the patients, doctors and other health staff involved suffers when compassion falls short. Compassion is essential for good patient care. This has been well documented and proven by Dr Stephen Trzeciak in his 374-page systemic review on compassion. More than 1000 articles from the best universities in the world were included in the review. Trzeciak is actually an intensive care physician and was initially convinced that he would find the opposite. Since he was the author with the most impact points at his university, he was commissioned by the dean of the university to find out whether compassion could and should play a role at their university. This was indeed the starting point of his search for scientific evidence, which ended in the book Compassionomics (Trzekiak, Stephen, Mazzarelli, 2019).

At this point, a few definitions are necessary, as *sympathy*, *empathy* and *compassion* are not synonyms and the difference is crucial.

- *Sympathy* means someone is likeable to me, I *like the* other person.
- *Empathy* means that I can put myself in the other person's shoes and, if necessary, empathise with their suffering. One can feel empathy without liking the other person or without liking the other person. If someone hits his thumb with a hammer and I observe it, I can think and empathise: "That must hurt!" Regardless of whether I am sympathetic to the other person or not.
- *Compassion* means feeling the pain of the other person and being motivated to help them. Compassion is empathy plus the urge to act.

Empathy is feeling.

Compassion is action.

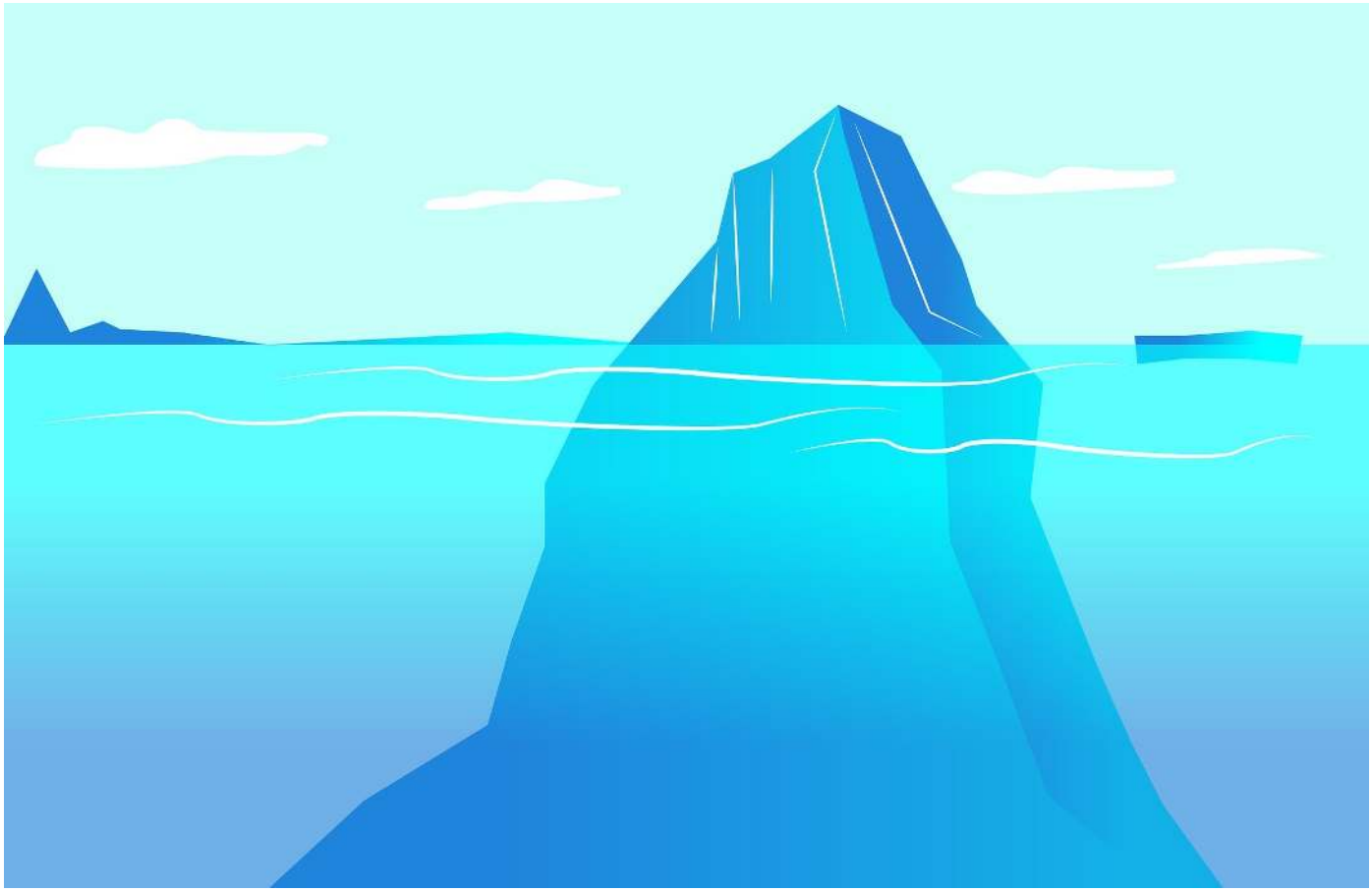
This also explains a phenomenon that is now well studied: those who show too much empathy are more at risk for burnout, a very common phenomenon especially in hospitals and health care professions (Trzeciak et al., 2017). However, those who have compassion are *less at risk for burnout* and depression. Why is that? Those who only suffer without actively doing anything suffer passively. One feels helplessness in the process. Learned helplessness leads to depression, PTSS, and burnout (*Toothless Skull Raises Questions about Compassion among Human Ancestors - Scientific American*, n.d.).) On the other hand, those who empathise and actively participate in improving the condition of others have the feeling of being effective. Furthermore, with empathy one identifies with the suffering of the other, with compassion one can differentiate that the suffering is not one's own. If you are then also able to help, or at least try and take action to, then the reward system in the brain is activated. This has been demonstrated with functional MRI (Klimecki et al., 2013). So there is a neurophysiological correlate for empathy and compassion being different things, and for one being more likely to lead to burnout and the other to protect against burnout and increase one's resilience. So bring on the compassion!

Now the bad news: you can unlearn compassion. And it is well studied when we unlearn compassion: while we become a doctor. In "doctors school", during medical school and in further training to become a specialist. Not one, but many studies have shown over decades and around the world that compassion and expressions of compassion decline during medical training in favour of fact-focused and factual communication. Because that is what is required and expected of us on a daily basis. (Trzekiak, Mazzarelli, 2019). If you think you're not an emotional person, that's just the way it is and there's nothing you can do about it (fixed mindset), here's the good news: compassion can be learned. Some people find it easier than others. But it is possible for everyone. Does a doctor-patient conversation in which the doctor expresses compassion take longer? Yes. On average, forty seconds. Forty seconds.

Conclusion:

- Sympathy, empathy and compassion are different things.
- Too much empathy can be harmful.
- Compassion strengthens the resilience of doctors and has a clinically measurable added value.
- Compassion improves patient outcomes, reduces costs and improves efficiency.
- Compassion can be learned (again).

It is possible that you can communicate on the factual level only.



After talking a lot about feelings, let's get down to business, shall we? And yes, you can communicate on a factual level, but not only. Without starting here with old hats and ears of Schulz von Thun. Every sentence we utter has factual information, which is sometimes more, sometimes less useful, and underlying emotional information. And about 90 % of this information is conveyed non-verbally or paraverbally. *How* we say something is at least as important as the content we want to convey. This starts with the simplest sentence you can say in English: Yes. A "yes" can have over 150 different meanings, depending on emphasis, facial expressions, gestures and posture. It can even mean "no". So if you think you can only communicate on a factual level and that would eliminate any misunderstanding, you are very much mistaken. That's where the misunderstandings start. About 90% of problems at work are due to interpersonal differences, not differences on factual issues. Just imagine saying "yes" while crossing your arms, leaning back and raising your eyebrows sceptically. Or you say "yes", lean forward and smile openly. Or you say boredly, "Yes, yes ..." Here is a real example from a communication training for midwives and expectant mothers. All the "meanings" of the statement, and how they were understood, came from mothers and midwives.

The sentence "My contractions are stronger now" from an expectant mother to the midwife can mean: My contractions are stronger now. A purely quantitative statement. Before 3, now 5 on a pain scale. The famous factual level. However, it can also mean:

- Give me a painkiller!
- Here we go.
- Is that normal?
- I need your help.
- I don't know what to do.
- Tell me what to do.
- It is unpleasant for me, but I can still stand it.
- I hope it will end soon.

That is one side. The other side is that of the midwife. She can understand the statement like this: The contractions are stronger now. And she can also understand it in the same way:

- Here we go, great.
- I'm supposed to give her a painkiller.
- I am supposed to guide them.
- She is coping well.
- She is not coping well.

The decisive factor in communication is usually not the mere words that are spoken. Only those who are aware of this and work on it can prevent misunderstandings and improve their communication. Self-perception and the perception of others with regard to one's own communication skills are often far apart, so that many doctors do not even know how they come across. Conclusion:

- It is not possible to communicate *only* on the factual level.
- The tone makes the music, and that always resonates.
- 90 % of problems at work are due to interpersonal differences and not differences on substantive issues.

An email does not replace a conversation

As a rule of thumb you can remember: The more important the topic is and the more emotions are involved for you or the other person, the closer I have to get to the other person. I don't mean that you should get nose to nose with him, but that an e-mail is not enough. It has to be at least a phone call so that the other person can hear my tone. Better is a face-to-face meeting. Why? As we have seen above, we cannot only communicate on a factual level and 90 % of communication does not take place with tone-deaf words. Even if the email is tone-deaf, we read it with a tone of voice in our own head. But in most cases, this tone of voice is not the one the sender had in mind when writing the email.

This has been investigated by Justin Kruger. In "Egocentrism Over E-Mail: Can We Communicate as Well as We Think?" (Kruger et al., 2005) he summarizes his findings. It becomes clear that we not only misjudge what the emotional undertone of the e-mail is that the sender had in mind. But also we ourselves are particularly sure that the other person will correctly understand the tone of the e-mail we write (although this is usually not the case). For two reasons: Firstly, we hear our tone of voice when we write the text; secondly, we find it difficult to put ourselves in the shoes of others. This is where the lack or lack of empathy comes into play again. We are more with ourselves when writing the email than we are empathizing with the other person. This is understandable and unfortunately leads to problems time and again. Of course, e-mail is one of the main means of communication and information at work. However, if important matters are at stake, or it appears that a conflict is brewing, pick up the phone or, better still, come around in person. As Justin Kerr, writes this in his book "How to Be Great at Your Job" (Justin Kerr, 2018). He doesn't work in a hospital, but he was a C-level executive at companies like Levi's, Gap and Old Navy. In other words, he probably writes more emails and faster than most people can dictate an OR report, and that's exactly why he meets up in person when it's important.

Conclusion:

- We always read an email with our voice in our head; this tone of voice gives the text its emotional message. However, this is often not the one the sender had in mind writing it.
- We are bad at assessing how and whether the emotional tone of our email is understood.
- Differences are not resolved by e-mails, but are most likely reinforced.
- The more important the matter, the more personal contact is needed.

The Golden Rule is crap

The „Golden Rule of Communication" is crap! Discover the platinum rule of communication and develop relationships and trust with staff and colleagues like never before. People often talk about the Golden Rule of Communication. It says that you should treat other people the way *you* would like to be treated. At first glance, this sounds conclusive and logical. The crucial mistake in thinking about this is: Not all people want to be treated the same. And the differences are greater than one might first assume.

A somewhat extreme example: A few years ago I asked a surgical colleague why he had put up with it for so long in a department that has a choleric boss who yells at his staff at regular intervals, often even daily. I couldn't understand it and even with the bad job situation at the time, I wouldn't have lasted long in that department. I couldn't have been more taken aback by the colleague's response: He told me he liked being yelled at, that it would motivate him to do his best. Even though this puts him in an absolute minority of people and I don't want to advertise loud or choleric colleagues, one thing is certain: I wouldn't want to be treated the way he likes to be treated. A less drastic example: many people are motivated to get recognition for their (good) work. They want to hear that they did something well, had a good idea or worked correctly and quickly. This is nothing out of the ordinary at first and maybe you feel the same way. Other people, on the other hand, want to be seen (first) as a human being before they are judged on their performance. They want the other person to see and accept them as a human being. This is also nothing unusual or special. However, it is very different from the previous motivation. Imagine that the first colleague applies the „Golden Rule of Communication", in the best sense, because he wants to praise and motivate the other person. He praises the work. Great job, done quickly, etc. The other person hears this, but thinks to himself: he only sees my work, as a person he doesn't care about me at all, there could also be a robot standing here, he probably wouldn't even notice. And is frustrated. But the other person really meant well! The other person wants to be treated the way he wants to be treated, not the way that would be most pleasant for you. Such misunderstandings occur every day and contribute to the demotivation of staff, colleagues and patients. People's needs here are individually very different. Not knowing them and inferring from oneself to others is a short circuit that blows the fuse in some people.

And how do I find out what motivates the other person? Let's say I want to have a positive relationship with the other person and make them receptive to what I want. The good news is: you can. The other person gives you clear clues that everyone can learn to read. The five behavioural clues - *words, tone of voice, gestures, facial expressions* and *posture* - reveal what is important to the other person and how they would like to be addressed and treated in order to have an open ear for your concerns, opinions and ideas. And that the other person listens to them and is open to their suggestions is what most people want. The cues show us what is important to the other person. Learning to understand them is the key to successful communication. Validated, tested for decades and successfully used by NASA, BMW, Apple, Pixar, Lufthansa and even in some hospitals. How this works in practice goes far beyond what can be presented in this short e-book.

If you want to know how, you can find out here and learn from me. I have been giving communication training for medical executives for over ten years and specialise in communication in hospitals. It is completely irrelevant whether you want to communicate with patients, colleagues, superiors or other professions. The principles are always the same and they also work in a private environment, with your partner or children. Learn more at www.drweinert.com or be brave and register for this seminar. The most medical associations, depending on country, award CME points for the seminars.

Summary:

Professionally, we are mostly good to very good, because professional topics made up 99 % of our education, training and continuing education.

However, 90 % of the problems at work are due to interpersonal differences and not to differences on substantive issues.

Training is almost non-existent here. The good news is that you can learn to do this just as well as you can learn to use an ultrasound machine.

Letting the other person talk for 30 seconds before interrupting already makes you a better doctor, who learns more and is perceived more positively just by this simple trick.

Medicine is in a crisis of compassion. Empathising with others brings many benefits, medical, human and economic, which are well documented and researched.

One cannot communicate only on the factual level. Every message has an emotional undertone that makes the music and determines how our factual information is understood.

The more important the topic, the more personal the conversation must be. E-mails do not convey any emotional tone, or usually the wrong one, and are not suitable for resolving conflicts, but rather only exacerbate them.

The "Golden Rule of Communication" is rubbish. People want to be addressed in different ways. This can be very different from how we would like it to be. And if we don't take this into account, we can exacerbate, create and promote conflicts, even though we act with the best of intentions. The platinum rule of communication is to address the other person as they would like to be addressed.

The good news is that all this can be learned!

What are the steps to better and optimal communication?

1. understand yourself. Self-awareness is the top trait of outstanding leaders, according to a Cornell University study (*In Business Nice Guys Finish First | AMA*, n.d.). And it can be learned.

2. deciphering and understanding the other person

3. put the two together to build trust and communicate in the best possible way.

Which step is the first for you?

Online training k2Me for self-knowledge with 1:1 online debriefing

(click here for information and registration)

Full On 3 Days Presence Communication Training

(Clickhere forinformation and registration)

Or arrange a free consultation and find out what suits you best and what goals you want to achieve.

(Clickhere for information and registration)

The author:

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With good communicaiton an humor everything is possible, without it: nothing works. 90% of problems at work are due to interpersonal differences, not differences on substantive issues. In the end everything is depended on good personal relations. I teach clear, practical and tailor made strategies that will help you getting ahaed in work and life.

Last but not least: When you think, or believe this ebook is useful for others, too: Then please share it using this Link!

DR. WEINERT COMMUNICATIONS