

Hospital Topics

No news is bad news: patients' views about communication in hospital

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"How many adult human beings are there, now, at this minute, rushing about in mute panic wishing they could find a doctor, the kind of person to whom they can pour out the fears they have deeply concealed?"—The Old Doctor in *Cancer Ward*, by ALEXANDER SOLZHENITSYN.

Summary and conclusions

One hundred patients on four general surgical wards in a large teaching hospital were interviewed about the information they had received about their illness and what they had been told about the investigations they had undergone. Fifty-five of them expressed some dissatisfaction and 14 were strongly dissatisfied. The way in which ward rounds were conducted was heavily criticised, but most patients did not object to the teaching of medical students at the bedside. Twenty-four patients would have liked more explanation about why investigations were performed, and 38 thought that they had not been told enough about the results of their investigations. This lack of information led to anxiety and fear. The findings suggest that more effort is needed to improve communication between doctors and patients.

Introduction

There have been spectacular advances in technology as applied to medicine, and individual patients have undeniably benefited greatly from wonders such as the artificial kidney and the CAT scanner. It is questionable, however, whether "medicine" in its broader sense is truly advancing so fast. Certainly, both Illich and Solzhenitsyn doubt that it is. We cannot afford to ignore the criticisms of these influential men and must therefore appraise with as much objectivity as we can muster the methods by which we practise medicine. Is it possible that despite great technological advances we are failing to meet other important needs, such as our patients' desire for information and explanation? Do doctors spend enough time talking to their patients?

In previous studies,¹⁻⁶ in which patients were interviewed some time after their discharge about the care that they had received in hospital, complaints about the difficulty of obtaining adequate information featured prominently. I undertook this

study in the hospital itself, to find out whether inpatients on four surgical wards thought that they had received enough information about their illnesses, investigations, and treatment.

Patients and methods

One hundred and thirty-three patients were interviewed on four surgical wards, two of which accommodated the university department of surgery and two of which were staffed by NHS surgeons. Of the 133 patients, 20 were found to be unable to converse because of severe illness or senility, and a further 13 were excluded because they had not undergone any investigations apart from routine tests of blood and urine. These 13 patients could, however, answer section 1 of the inquiry. The remaining 100 patients were eligible to answer the whole questionnaire. They had a wide variety of diseases, ranging from haemorrhoids to carcinoma (table I). They were divided into two groups of 50 patients, each of which contained 25 men and 25 women. Patients in one group received questionnaires in which the statements in section 4 (see below) were phrased negatively, while patients in the other group received questionnaires in which the statements in section 4 were phrased positively.

TABLE I—Diagnosis on admission of 100 patients who participated in questionnaire on communication between doctors and patients in hospital

Carcinoma of alimentary tract	No	Undiagnosed abdominal pain	No
Gall stones	23	Abscess	4
Peripheral vascular disease	18	Haemorrhoids	3
Hernia	9	Oesophageal stricture	2
Peptic ulcer	6	Carcinoma of breast	2
Appendicitis	5	Thyroid disease	2
Inflammatory bowel disease	5	Miscellaneous	9

Because some of the patients were unaware of the nature of their illness I decided to ask a series of specific questions about the investigations that they had undergone, before beginning a more general discussion about communication in hospital. At the start of the interview I established that the patient had been in hospital long enough for several investigations to have been performed. If the patient had only recently been admitted the interview was deferred for a few days. The questionnaire consisted of four sections.

(1) *Information booklet*—All patients were supposed to receive an information booklet before or at the time of their admission to hospital. This booklet contains general information about hospital routine and facilities and also a key to enable patients to identify different categories of hospital staff. Patients were shown the booklet and asked:

- Have you seen this booklet before?
- Have you looked through such a booklet?
- Do you think the booklet is useful?

(2) *Recall of investigations*—Patients were asked to recall all the tests and investigations that they had undergone during their stay in hospital. The accuracy of their recall was checked later by consulting the records in their case notes.

(3) *Chest x-ray examination*—This was an attempt to find out what patients remembered being told about one particular investigation. Since the chest x-ray examination was the only investigation common to all patients, each patient was asked:

- (a) Do you know why a chest x-ray is necessary?
- (b) Were you told what to expect before the chest x-ray was performed?
- (c) Did anyone explain to you what was going on during the test?
- (d) Do you know the result of your chest x-ray?

(4) *Patients' opinion of the information given about investigations*—Each patient was asked to complete the following questionnaire:
Dear Patient,

You will have had many tests since you came into hospital. Please read the following statements about these tests and write a number from 1 to 5 in the brackets for each statement, according to how much you disagree or agree with what it states.

- (1) means "I strongly disagree" with the statement
- (2) means "I disagree" with the statement
- (3) means "I neither disagree nor agree" with the statement
- (4) means "I agree" with the statement
- (5) means "I strongly agree" with the statement

- (a) I think that I was given enough idea about how long the tests would take ()
- (b) I think that I was given enough warning before the tests of what to expect ()
- (c) I think that I was given enough explanation of what was going on during the tests ()
- (d) I think that I was told enough about why the tests were necessary ()
- (e) I think that I was told enough about the results of my tests ()

Half the questionnaires were as above, with the statements phrased positively. In the remainder the statements were phrased negatively. For example, question (a) read: "I think that I was *not* given enough idea about how long the tests would take." In sections 1, 2, and 3 all the questions were asked by a single interviewer. Most of the patients completed section 4 themselves, but if they were prevented from doing so by their illness the interviewer wrote down the answers for them. The interview was completed by a general discussion in which an attempt was made to assess the patient's opinion of the quality of communication between doctors and patients in hospital.

Results

INFORMATION BOOKLET

Seventy-four (66%) of the 113 patients interviewed had never seen the information booklet. Of the 39 patients who had seen it, 38 had looked through it and all of these thought that it was useful. Two patients made suggestions for improvements.

RECALL OF INVESTIGATIONS

The number of investigations undergone by each patient ranged from two to eight (mean 4.5). Although patients did not always know the name of an investigation, they could describe it in easily recognisable terms. Eighty-two patients correctly recalled every investigation that they had undergone and the others could recall most of their investigations.

CHEST X-RAY

Seventy patients knew why a chest x-ray examination had been necessary. Before the examination had been performed eight patients had been told what it entailed. Fifteen patients had been given some explanation about the procedure while it was actually being performed. Only 18 patients knew the result of their chest x-ray examination (table II).

TABLE II—Answers given by 100 patients to questions on chest x-ray examination

Question	Answer	
	Yes	No
(a) Do you know why a chest x-ray is necessary? ..	70	30
(b) Were you given prior warning of what to expect? ..	8	92
(c) Did anyone explain to you what was going on during the test? ..	15	85
(d) Do you know the result of the chest x-ray? ..	18	82

PATIENTS' OPINIONS ABOUT INFORMATION RECEIVED

Fifty-five of the patients interviewed expressed some dissatisfaction with the information that they had received about their investigations (table III). Fourteen patients expressed strong dissatisfaction. There was no important difference between men and women in the degree of dissatisfaction. When patients in different age groups were compared no important differences in levels of dissatisfaction were found. Patients who had been asked to reply to negatively worded statements were found to be no more dissatisfied than patients who had been asked to reply to positively worded statements. Fifty-six per cent of patients who were under the care of NHS consultants registered some degree of dissatisfaction, compared with 54% of patients who were cared for in the university department of surgery.

TABLE III—Number of patients who were dissatisfied with the information that they had received about their investigations

Type of information	Dissatisfied	Strongly dissatisfied	Total
(a) How long investigations would take ..	22	1	23
(b) Prior explanation of what to expect during the investigations ..	23	5	28
(c) Explanations given during investigations ..	29	1	30
(d) Why the tests were necessary ..	20	4	24
(e) Results of tests ..	27	11	38

PATIENTS' OPINION ABOUT THE QUALITY OF COMMUNICATION IN HOSPITAL

During these interviews patients expressed diverse opinions about the quality of communication in hospital, but certain themes recurred again and again. The conduct of ward rounds, for example, provoked heavy criticism. Patients disliked the way in which they were excluded from discussion by doctors who muttered among themselves at the end of the bed, using incomprehensible medical jargon. Such behaviour was regarded as insulting: patients thought that the doctors were underestimating their intelligence. For example, a 49-year-old man with peripheral vascular disease who had undergone a lumbar sympathectomy said: "On the ward rounds there are two professors, two senior registrars, Old Uncle Tom Cobley, and all—they discuss you among themselves and say 'It'll be all right . . .' pat you on the head as it were, and stick another lollipop in your mouth." Another commented, "We're not morons. Education has advanced, and I think you should be treated as an intelligent person."

Most patients expressed no objections to the teaching of medical students at the bedside; two patients said they had enjoyed the opportunity to learn more about their illnesses. Nevertheless, two others had been upset by the experience, and one of these commented, "There's a difference between the pulses in my right and left groins—about 25 students have felt them, but I still don't know what it means, or what the consequences are." Twenty-four of the patients wanted more explanation about why investigations are performed. Blood tests and chest x-ray examinations in particular were often done without any explanation. For example, a 26-year-old student who had undergone operation for haemorrhage from a duodenal ulcer said: "Two days after my operation, I was suddenly taken off to x-ray. No-one told me why. I was worried."

Patients were keen to learn the outcome of their investigations, but often were not told. "I'd like to have known if my chest x-ray was clear, but none of the doctors has mentioned it." This led to anxiety: "You get the feeling sometimes that there is something worse wrong than they've told you, because they don't explain" (from a man with an inguinal hernia). Another commonly held view was that unless the patient asked questions, he or she would not be given information; yet many patients felt inhibited about asking questions. This was particularly true of the older patients, who often said that they thought that it was not "their place" to ask. They were still in awe of the doctor. Some patients failed to understand medical terms, but did not ask questions because they were afraid of looking foolish in front of the doctors or other patients on the ward who could hear what was being said. Others who *had* asked questions felt that they had been fobbed off with rather perfunctory replies. A consequence of this alleged lack of candour on the part of the doctors was a loss of trust and confidence in them. Thus, a woman with Crohn's disease, who complained that doctors had avoided answering her questions, went on to say: "I thought up till now that I had cancer. I asked the

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doctor, and he said 'no,' but I still think it's that—you can't believe them."

Four patients thought that they had been treated as objects rather than as people with emotional needs, and eight patients who said that they had been given insufficient information thought that they were being denied their rights. As one said, "After all, it's my body they're operating on . . ." Or again, as a 61-year-old man with oesophageal stricture said: "They never told me why they sent me out the first time. They wrote to my doctor and he told me. I never knew what was wrong, yet I'm the one concerned. It's my life." As to the diagnosis itself, clearly patients feared the unknown much more than they feared the truth about their illnesses, however serious these might be. "I think they should tell you without your having to ask. If you are told, it stops you worrying. I should like to know, even if it's unpleasant; at least you know what to expect. I felt so ill that I guessed I had cancer. This time when I felt the lump, I didn't have the same anxiety. I've got more peace of mind" (a 52-year-old housewife with recurrent gastric carcinoma). Some patients also thought that if they understood their illness better they would somehow find it easier to "resist" it: knowing the truth would enable them to co-operate better with the staff in their treatment, and to deal sensibly with their affairs and family responsibilities.

To complete the picture, some 10% of patients interviewed, particularly the elderly, wanted to know little or nothing about their illness. As an 83-year-old woman said, "I leave my life in their hands, and let them do what they want to do. After all, it's for my own good."

Discussion

These findings are disturbing. Each patient was supposed to receive an explanatory booklet about the hospital, yet no fewer than 66% of patients had not received it. Patients were found to be intensely interested in their investigations—82% of them could correctly recall every investigation they had undergone—but most thought that the information that they had received before, during, and after each investigation had been inadequate. Patients had often been inadequately prepared mentally for potentially frightening procedures such as arteriography or endoscopy, and many had not been told the results of their investigations. Thus only 18 patients knew the results of their chest x-ray examination. No fewer than 55 of the 100 patients who were interviewed expressed some degree of dissatisfaction with the quality of communication in hospital, and 14 were strongly dissatisfied.

It was disappointing to find this state of affairs in a large teaching hospital, a "centre of excellence." Are patients in small hospitals and in non-teaching hospitals equally dissatisfied? Lest the reader should suspect that the surgical staff of the Bristol Royal Infirmary were unique in producing such a degree of dissatisfaction among their patients, I should point out that the results of studies carried out in other parts of Britain have highlighted similar dissatisfaction among patients.¹⁻⁶ For example, in a study carried out by Cartwright¹ in 12 randomly selected districts in England and Wales, over 700 former hospital inpatients were interviewed in their homes. Sixty-one per cent of these patients said that they had experienced some difficulty in obtaining information while they were in hospital, and 29% of them voiced serious dissatisfaction. Thus patients all over Britain apparently fail to receive the information that they would like to have about their illnesses. Many of the weaknesses highlighted in the present survey have already been the subject of adverse comment in the press,⁷ on television, and in the writings of authors such as Illich⁸ and Solzhenitsyn.⁹ Thus the problem is not confined to Britain.

Anxiety and fear are the inevitable consequences of poor communication between doctors and patients. In this study, for example, patients with perfectly normal results of chest x-ray examinations were found to be worrying about the result of the investigation because nobody had troubled to tell them. Again, a patient with an inguinal hernia was found to be worried that it was "something more serious," and a patient with benign peptic ulcer was convinced that he had cancer of the stomach. To most patients in hospital fear of the unknown is a much heavier

burden to bear than full knowledge of their illness, however serious that may be. Some patients said that they were almost relieved when they knew the worst; they felt calmer, and better able to co-operate with the surgical team in fighting their illness. Others were glad to know the whole truth so that they could deal rationally with their family commitments. In short, to patients in hospital, "no news is bad news."

There is some evidence that patients who are worried and anxious actually take longer to recover from an operation than patients who have been given adequate information. At the Massachusetts General Hospital, Egbert *et al*¹⁰ found that patients who were reassured before operation about what to expect in the postoperative period and who received special encouragement after operation needed only about half the amount of narcotic drugs needed by control patients who had not been similarly reassured or encouraged. They were also ready for discharge from hospital an average of two days sooner than the control patients. There is a defence, of course. Patients, after all, are fallible. No doubt some who claimed ignorance and criticised the "system" had in fact received adequate information, but had either forgotten it or had misunderstood what they had been told. It is also important to keep the results in perspective and to emphasise that, although a small minority of patients (14%) expressed strong dissatisfaction with the quality of communication in hospital, most were grateful for the kindness and high quality of care that they had received.

As to the accuracy of the observations, the greatest potential source of bias lay in the phrasing of the questions in section 4, because a patient who is asked negatively phrased questions such as "are you dissatisfied?" might well be thought more likely to express dissatisfaction than a patient who is asked more positively phrased questions such as "are you satisfied?". In the event, however, it did not seem to matter how the questions were asked, because the level of dissatisfaction recorded was no greater when the questions were phrased negatively than when they were phrased positively. It was also found that the incidence and degree of dissatisfaction were roughly equal in men and women, that the patient's age had little bearing on the results, and that patients of NHS consultants were neither more nor less dissatisfied than patients of consultants in the university department.

If it is accepted that many doctors in hospitals do not communicate adequately with their patients, what can be done to improve matters? The sheer physical surroundings of most Nightingale wards are inimical to good communication, because they make private, intimate conversations between doctor and patient very difficult to achieve, and quite impossible if the patient is hard of hearing. Furthermore, if patients are to be told in advance all about their investigations, and then told the results afterwards, and if their fears and anxieties are to get a proper hearing, doctors will have to spend more time talking to patients. It is hard to see how this extra time can be found, because consultants, registrars, and house officers alike are already hard-pressed. Perhaps the predicted surfeit of newly qualified doctors may ease the work load and free more time for the important task of transmitting information to the patient (though I doubt it). Another aspect of the problem is the *quality* of communication between doctor and patient. In the past, little or no time has been spent in the formal teaching of communication skills. Nevertheless, some groups of teachers and students have been experimenting in this field, using videotape recording of interviews between students and patients (either real patients or actors). Meadow and Hewitt¹¹ have described a course for medical students that uses this technique. They found that when the interviews were played back, students learnt a lot from viewing their own performance. For example, it brought home to them their apparent lack of sympathy, their tendency to use medical jargon, their imperfect explanations. If this type of activity becomes an accepted part of the undergraduate medical curriculum, the ability of doctors to communicate with their patients might correspondingly improve. That is surely as important a part of patient care as

the routine measurement of serum electrolyte concentrations.

In conclusion, talking to patients during this study has taught me how much they appreciate a doctor who has taken a real interest in them as human beings, and who has been prepared to inform, explain, and answer any questions they might have. A patient summed this up by describing her feelings about one member of staff: "Mr X will talk to you. He doesn't make you feel that you're just another piece of furniture, he makes you feel you're an individual. I'd like to think that all doctors could be like that."

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A reorganised medical division

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Hospital development in north Staffordshire was piecemeal before 1948; even after this the medical division existed in little more than name until 1967, when the physicians planned a reorganisation to improve the service and to use resources more efficiently.

This report describes the reorganisation and its effects. It was carried out against a hospital background similar to that found in many large British towns and cities. The difficulties therefore are common, and our solutions might be applied elsewhere.

The problem

The North Staffordshire Royal Infirmary, with 97 general medical beds, and the City General Hospital, with 170 general medical beds, lie a quarter of a mile apart. Most specialist units are at the infirmary, as is the only accident unit in the district. The psychiatric unit and the coronary care unit are at the City General Hospital. This disposition of beds, being fortuitous and historical, was hard to change, and any improvements had to be made with the existing beds. Interchange of medical and surgical beds was impossible without disturbing the balance between surgical beds and theatres.

It had proved impossible to provide room for all emergency admissions in the two wards allocated to the duty physician each day. Consequently, wards not on call had to accept emergency admissions, even though they were inadequately staffed for this. After a busy day seriously ill patients would be found throughout the medical wards in both hospitals. This imposed an intolerable demand on the nursing staff and made it difficult for the medical staff to provide satisfactory care.

All the wards fulfilled a multipurpose function for the physicians in charge of them, being used primarily for patients admitted as emergency cases (and later for their convalescence) but also serving a minor role for investigating and treating "cold" cases. Patients

admitted for cold investigation or treatment had to be inserted when possible into wards concerned chiefly with an emergency commitment. The mix of patients, each needing different degrees of nursing, served none of them well; added to the confusion were random, acutely ill patients. It seemed that if emergency medicine could be organised, then all else would follow and the whole medical division would benefit.

Reorganisation

The conventional ward, which had beds allocated to individual physicians and which attempted to fulfil these different functions, seemed to bar the rational development of both nursing and medical care. As a preliminary to total reorganisation of the service in general medicine the physicians agreed to abandon the allocation of beds to individual physicians. They also agreed that patients' needs would be met best by separating three areas offering different levels of care: (a) a high dependency unit (HDU), (b) an intermediate area, and (c) a planned investigation unit.

PLANNED INVESTIGATION UNIT

The planned investigation unit, which has 10 beds, is not the major concern of this report. It was formed by reallocating one medical ward and is staffed by a sister and an auxiliary nurse. The unit has worked well in the three years it has been open, and 411 patients were investigated in 1977. Its work is still increasing.

HIGH DEPENDENCY UNIT

A centre for the emergency service was created by the release of three of the six medical wards in a block at the City General Hospital. A pair of wards of the ground floor were adapted to make the unit. Each ward was redesigned to hold 14 beds and two beds in single rooms. A four-bed ward was made for intensive care. An x-ray department, added to the ward block, was planned to offer a comprehensive radiological service apart from arteriography and was equipped with a skull unit, moving top table, and a screening unit. All beds except those in the single rooms had monitor points with a six-channel console at the nurses' stations in each ward. Oxygen was piped to each bed and suction points were made to serve all beds.

Two bedsitting rooms were made for junior medical staff and

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