EFFECTIVE COMMUNICATION IN THE INPATIENT CARE SETTING: AN ESSENTIAL COMPETENCY FOR HOSPITALISTS

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Since the term *hospitalist* was first used 10 years ago to describe a new type of physician specializing in inpatient care [1], the field of hospital medicine has exploded. Today, the number of hospitalists practicing in the United States is estimated to be at least 15,000, with that number expected to double by 2010 [2].

The increasing presence of hospitalists within the health care system underscores the need for these physicians to possess the skills and knowledge required to provide high-quality, efficient care for hospitalized patients. Recognizing this need, the Society of Hospital Medicine published a set of core competencies designed to help standardize the education and training of hospitalists [3]. The competencies address 3 main functions of hospitalists. In addition to demonstrating proficiency in treating certain *clinical conditions* (eg, venous thromboembolism, hospital-acquired pneumonia) and performing certain clinical *procedures* (eg, lumbar puncture, thoracentesis), hospitalists must demonstrate the ability to fulfill key roles in improving *health care systems*. Significant among these health system roles is the ability to communicate effectively with patients, hospital staff, and other physicians, such as primary care physicians (PCPs) or clinical consultants.

The importance of effective communication in hospital care cannot be overemphasized. However, communication in inpatient settings is often fragmented, and these communication failures are frequently cited as a major factor in adverse events. In fact, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reports communication failures as the root cause of more than 70% of *sentinel events*, adverse events JCAHO defines as "any occurrence involving death or serious psychological or physical injury or the risk thereof" [4]. Effective communication is particularly important at times of transition, such as when a patient is discharged from the hospital or when patient care responsibility transfers from one hospital staff member to another at shift change [5–7]. Given the frequency of care transitions that occur during a patient's hospitalization and the potential for these care transfers to result in inefficient or suboptimal care, hospitalists have a unique opportunity to learn, practice, and promote effective communication practices that can improve patient care. Even with a clear need for more effective communication in the inpatient care setting, few professional development or training programs are offered in this area.

This article uses a case scenario to illustrate the major domains of communication for hospitalists that impact on the quality of inpatient care (**Table**). These domains include interaction between hospitalists and 1) other health care professionals in the multidisciplinary care team (eg, nurses, case managers, pharmacists), 2) patients and their family members or caregivers, 3) other hospital physicians and personnel at the time of hand-offs, 4) PCPs, and 5) home health professionals. Common barriers to effective communication within each domain are identified, and strategies to overcome these barriers are suggested.

Communication in a Multidisciplinary Team

Early Monday morning, Dr. Morales, a hospitalist at University Medical Center, is rounding on the inpatient general medicine ward with Mr. Irving, a physician assistant. As they discuss each patient's plan of care, Dr. Morales relays to Mr. Irving discharge planning issues and home health needs for each patient. Midway through rounds, Dr. Morales is contacted by the emergency department (ED) regarding a patient who was admitted with a suspected new deep vein thrombosis (DVT). As he rushes off to the ED, Dr. Morales fails to reveal the details of the case to Mr. Irving and the suspicion of a new DVT.

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Table. Communication Competencies for Hospitalists

Communication Domain	Participants	Barriers to Effective Communication	Strategies for Success
Communication within a multidisciplinary inpatient care team	Nurses, physician assistants, pharmacy staff, case managers, social workers	Adhering to a hierarchical structure in which the physician is the "assumed" leader and thus dominates clinical decision making and trumps the contributions of other team members Redundancy (relaying the same information multiple times to multiple individuals) contributes to re-work and inefficiency	Use multidisciplinary rounds with contribution of all team members in order to coordinate the plan of care Perform daily rounds as a team in order to eliminate redundancy/re-work
Communication with patients	Patient, family members/primary caregivers	Use of medical jargon the patient does not understand diminishes the patient's role in the therapeutic partnership Short-term relationship with the patient generates a sense of unaccountability on the part of the hospitalist No previous relationship with the patient limits the hospitalist's ability to understand the patient's wishes, values, and insight into disease	Promote therapeutic partnership through use of lay language, appropriate introductions, and explanation of the hospitalist's role in the patient's care Assess the patient's understanding of the disease process and previous communication between the PCP and patient regarding the patient's wishes, values, and insight into his/her disease
Communication during in-hospital hand-offs	Admitting physician (ED, PCP), covering physicians (nocturnists, other hospitalists, housestaff)	Competing time pressures, distractions, and interruptions lead to ineffective transfer of patient information, resulting in communication breakdowns (eg, omissions)	Allot time for a structured and standardized hand-off process to ensure quality care, such that all essential patient information for continuing care of the patient is accurately documented and transferred to those who need it
Communication with PCPs	PCP, ancillary staff involved in patient's outpatient management	Competing time pressures interfere with the hospitalist's ability to transmit, in a timely fashion, important information to the PCP regarding the patient's hospitalization Involving the PCP only at discharge without relaying information regarding hospitalization prevents the PCP from contributing to the inpatient plan of care	Ensure timely involvement of the PCP in all aspects of the patient's hospitalization, especially in relation to admission, discharge, change in status, and major interventions
Communication at time of discharge	Home health care professionals (eg, nurses, physical therapists), PCP, family members/primary caregivers	Competing time pressures and ineffective communication among members of the interdisciplinary team prevent the timely transmission of accurate information related to the patient's hospitalization	Ensure systems are in place for adequate transmission of desired information, including plans for follow-up and the initiation of new therapies

ED = emergency department; PCP = primary care physician.

He subsequently departs for the ED to evaluate this new admission, leaving the inpatient service in the care of Mr. Irving.

As Dr. Morales leaves the floor, Mr. Irving first calls the staff social worker to relay the discharge planning issues just discussed with Dr. Morales. He then contacts the inpatient case manager to inform her of these issues as well. Afterward, Mr. Irving continues to round from patient to patient, contacting Dr. Morales, the social worker, and the case manager as new updates arise.

Promoting Team Efficiency and Improving Patient Care

In the opening scenario, we see Dr. Morales on a typical day as a hospitalist. It appears that Dr. Morales works within a team of other health professionals (physician assistant, case manager, social worker), although only the physician assistant member of the inpatient care team joins him on morning rounds. Dr. Morales clearly depends on these other team members to help carry out the care plan for each of his patients, and thus, they are integral and equal players in the process. The physician assistant ensures that inpatient orders are fulfilled and that appropriate diagnostic tests are performed, and the inpatient case manager and social worker focus on the care of the patient outside the hospital setting, establishing and arranging home services and follow-up. Hospital work flow and the average daily life of a hospitalist rely upon this interprofessional communication and multidisciplinary care approach. Effective communication between team members allows for ease of work flow, ensuring clear delineation of the goals and objectives of each team member and tasks to be achieved.

Excellent inpatient care is not provided by one person acting alone. It requires the coordinated efforts of a multidisciplinary inpatient care team. This team generally consists of clinically focused members (eg, physicians and/or hospitalists, physician assistants and/or nurse practitioners) who are responsible for the patient's medical care and nonclinically focused members (eg, social workers, case managers) who provide the social and personal aspects of patient care (eg, facilitate discharge planning, arrange home and social services). Although specific team structure may differ from hospital to hospital, this general framework of a team with both clinically and nonclinically focused members is universal.

The multidisciplinary approach to inpatient care is dependent upon effective interprofessional communi-

cation, a core competency for hospitalists. Achieving effective communication between members of multidisciplinary care teams requires overcoming common barriers. An important obstacle is the rigid, hierarchical team structure that typically exists in the inpatient care setting, in which the physician is often "assumed" to be the leader of the team and, as such, team decision making (and the weight given to each member's input) is often skewed to over-represent the physician's viewpoint. In some instances, clinically focused members of the team will not relay vital information regarding a patient's diagnosis and treatment to nonclinically focused members, incorrectly assuming that such details are beyond the scope of involvement of those individuals. This tendency may have contributed to Dr. Morales' failure to divulge critical details regarding the new admission to the physician assistant member of his team (Mr. Irving). The presumption—of external observers and at times the individual members of the team—that the physician is the leader and, thus, is in a position of power over other team members is incorrect. Each player contributes to the total care of the patient and must be valued as such in order for the multidisciplinary team to thrive.

Another common communication problem within teams that can undermine effective multidisciplinary inpatient care is redundancy—relaying similar information individually to the members of the health care team [8]. Clearly, Mr. Irving spends a considerable amount of time performing duplicative work, relaying the same information about each patient's needs to each member of the team.

To overcome these barriers, it is especially important for hospitalists to establish an environment in which each member of the inpatient care team has the opportunity to participate in the essential components of the plan of care. It is through the coordination of the efforts of multidisciplinary team members that hospitalists can provide the highest quality experience for their patients. One way to promote this strategy for success is to view hospital rounds as a team effort. Using multidisciplinary rounds, with all members of the health care team present, assists in focusing the plan of care by allowing for each member's input. Importantly, rounding as a team also eliminates communication of redundant information. In fact, the use of a multidisciplinary model, with the collaboration of hospitalists and allied health professionals, has been shown to decrease length of stay and to have a positive impact on hospital costs [9].

Communication with Patients

In the ED, Dr. Morales finds Mrs. Woods, the newly admitted patient, and introduces himself.

"Good morning, Mrs. Woods. I am Dr. Morales, a hospitalist here at University Medical Center. I see that your physician, Dr. Cooper, has referred you here because she suspects a new DVT. We will be performing an ultrasound of your lower leg to confirm her suspicions and will be giving you blood thinner, as there is a risk that a clot in your leg may travel to your lungs and become fatal."

At this point in the interview, Dr. Morales' pager begins to beep with a call from Mr. Irving with an update on patients on the general medicine ward.

Dr. Morales turns to Mrs. Woods and hurriedly states, "I have to answer this important call, Mrs. Woods. When we have more information, we will discuss the results with you."

Dr. Morales then leaves the curtained ED room.

Promoting Partnership with Patients

Effective communication with patients—to provide education and promote patients' involvement in their own care—is another essential skill for hospitalists. Although seemingly common sense, an introduction that establishes the physician's role in the care process is often overlooked in routine interactions with patients [10]. Dr. Morales demonstrates this troublesome tendency, as he neglects to explain his specific responsibilities in Mrs. Woods' plan of care. This simple task not only improves patient understanding, it also has the potential to improve patients' satisfaction with their care. In fact, poor communication with patients by physicians, in particular the communication of information regarding medical errors, has been associated with increased numbers of medical malpractice suits [11].

By clearly highlighting his role as an inpatient physician and reassuring Mrs. Woods that her PCP will be informed of all diagnostic decision making, Dr. Morales could promote the therapeutic alliance between himself and Mrs. Woods. However, in this scenario, these opportunities for communication are missed. This is particularly important in the inpatient setting, since patients are often unfamiliar with their inpatient physicians at a time when they feel most vulnerable and least empowered to care for themselves due to acute illness. In fact, the lack of a prior relationship of hospitalists with their patients can be a major impediment to achieving effective communication with patients. Dr. Morales neglects to pursue important issues, such as Mrs. Woods' understanding of her illness and need for hospitalization, her wishes as they pursue treatment of this condition, and the previous communication that took place between her and her PCP. Identifying and discussing these issues is critical for forging a therapeutic relationship between the hospitalist and the patient.

The first patient encounter is also an especially important time to set the agenda for the hospital visit. Dr. Morales clearly misses these opportunities with his cursory evaluation of Mrs. Woods. His use of acronyms to explain her condition and the casual manner in which he presents potentially fatal complications may serve to heighten her anxiety and generate needless confusion. Instead, by explaining the patient's condition and therapy in lay terms and avoiding medical jargon, Dr. Morales would be able to provide Mrs. Woods with a clearer picture of what issues will arise during her admission. Finally, in his rushed exit, Dr. Morales denies the patient the opportunity to raise questions regarding her potential diagnosis and therapeutic options. By soliciting questions from the patient and addressing concerns that she has regarding her hospitalization, the notion of the patient as an active participant in her medical care could be reaffirmed.

Communication During In-Hospital Hand-offs

As Dr. Morales rejoins Mr. Irving to discuss implementation of discharge plans for their service, he briefs Mr. Irving on the new admission, providing him with the patient's name and anticipated location and informing him to order lower extremity Doppler studies. Dr. Morales quickly drafts admission orders for Mrs. Woods, including intravenous (IV) anticoagulation with heparin, and requests that Mr. Irving place the orders in the chart when Mrs. Woods arrives on the floor. He then departs to see the remaining patients on the service.

As he places the admission orders in the chart, Mr. Irving is approached by the general medicine floor nurse, inquiring as to why Mrs. Woods is leaving the floor for Doppler studies and why she requires IV anticoagulation. Unaware of Dr. Morales' suspicion that the patient may have a DVT, Mr. Irving pages Dr. Morales and waits for answers.

Later that evening, as Dr. Morales plans to leave for the day at the close of his shift, he prepares a written sign-out sheet consisting of the names of the patients on his service, their location within the hospital, and a 1-line description of their active medical issues. The night-covering physician arrives for duty and finds the sheet prepared by Dr. Morales posted on the workroom

bulletin board. Overnight, the covering physician is contacted by the coagulation laboratory regarding an abnormal prothrombin time value for Mrs. Woods. In his haste, Dr. Morales had omitted Mrs. Woods (and the fact that she had been placed on IV anticoagulation) from the sign-out sheet. The covering physician heads to the hospital wards to refer to the chart and determine the active medical issues with Mrs. Woods in an attempt to clarify the etiology of the abnormal laboratory value.

Ensuring Safe and Effective Transfer of Care

Times of transition, or hand-offs, can be particularly prone to breakdowns in communication [5]. As Mrs. Woods makes the transition from the ED to the inpatient general medicine wards, accurate communication between each of the members of the inpatient care team is essential to ensure that critical orders (eg, plans for procedures or studies) are carried out. In this scenario, direct communication between members of the inpatient care team and ancillary staff would assist in clarifying the plan for Mrs. Woods' admission and serve to explain subsequent orders. By relaying to the covering staff nurse that the patient is having Doppler studies and is receiving IV anticoagulation because of a presumed DVT, the physician assistant could involve the staff nurse in the plan of care and help to answer questions that may arise during Mrs. Woods' stay.

However, the communication breakdown between the attending physician (Dr. Morales) and the physician assistant (Mr. Irving) impacts all members of the multidisciplinary health care team, as the lack of information regarding Mrs. Woods' admission prevents Mr. Irving from relaying important details to the general medicine floor nurse. This in turn truncates the primary nurse's ability to inform and educate the patient, which can help to reinforce the diagnostic and therapeutic plan. In addition, the initiation of new medications with significant side effects, such as anticoagulants, requires the coordination of multiple members of the health care team, and the patient's understanding is pivotal to successful implementation. Patient education regarding a new medication, including an explanation of the drug's role in her care, ensures that she remains informed; reinforcing the importance of the medication to the patient serves to improve patient adherence.

Finally, continuity of care and patient safety require an accurate and up-to-date hand-off between the hospitalist and the night-covering physician. Hospitalists often work schedules with 8- to 12-hour shifts, requiring them to transfer care of their patients at the end of a shift to those reporting for duty. Ensuring that pertinent information is transmitted to these covering physicians for each patient, including medications and their dosages, plans for diagnostic testing, and code status, improves the quality of care delivered when the primary admitting physician has completed his or her day. As our case demonstrates, Dr. Morales' haste in leaving for the day results in the omission of vital information, including the details surrounding Mrs. Woods' admission and the medications that she is receiving. This failure in communication results not only in re-work for the night-covering physician but can potentially result in adverse patient outcomes, as the covering physician is unaware of the patient's active medical issues and the therapies instituted. Often, competing priorities and time constraints can hamper an effective hand-off, potentially resulting in failures of communication (eg, omissions) that can negatively impact patient care [5].

Factors contributing to successful hand-off communication that have been identified include face-to-face communication and use of a read-back strategy to reinforce and teach important information [6]. Clearly, by leaving his written sign-out sheet tacked to a bulletin board, Dr. Morales misses the opportunity for in-person communication and denies the covering physician the opportunity to raise questions and, thus, acquire pertinent patient information. The use of standard hand-off processes, with an opportunity for interactive questioning, was recently implemented by JCAHO as a National Patient Safety Goal [12]. This mandate recognizes the importance of good verbal communication at the time of patient hand-offs.

Communication with Primary Care Physicians

Early the following morning, Mrs. Woods undergoes Doppler ultrasound of her lower extremities, which reveals an acute DVT. Dr. Morales is informed of the results while rounding on the general medicine ward, and he begins to consider the possibility of discharging Mrs. Woods home with subcutaneous injections of an anticoagulant and oral warfarin. He relays this information to Mr. Irving, who subsequently discusses the case with the team's case manager to confirm whether Mrs. Woods' health insurance will cover the cost of the medications.

As he continues on rounds, Dr. Morales contacts Mr. Irving and requests that he also arrange daily home nursing visits for INR (international normalized ratio) blood tests for Mrs. Woods. Again, Mr. Irving contacts the case manager with the update to the plan of care. The case manager checks and confirms that Mrs. Woods' health insurance is adequate

to cover the current plan of care. In light of this, Dr. Morales and Mr. Irving explain to Mrs. Woods that she will need anticoagulation for a short period of time and that Dr. Cooper will be following her blood test levels as an outpatient. As rounding continues, Dr. Morales drafts a brief email message for Dr. Cooper, stating that Mrs. Woods' Doppler studies were indeed positive and that she will be discharged later that day.

Promoting Continuity of Care

One of the primary goals of a hospitalist is to deliver high-quality care to patients who are hospitalized for acute complaints. However, the success of such a patient's hospital care plan depends on critical communication between the hospitalist and the patient's PCP, who is responsible for managing the outpatient facet of the patient's care [13]. Many PCPs feel that communication regarding their patients' hospital care is suboptimal [14]. This is not surprising if the preceding scenario is representative of what many PCPs experience in practice.

Again, breakdowns in communication are noted as Dr. Morales relays only minimal information regarding Mrs. Woods' hospital course and treatment to her PCP, Dr. Cooper. Not only have the details surrounding the addition of a new medication (an anticoagulant) been omitted, but Dr. Morales also neglects to mention vital test results obtained during Mrs. Woods' hospitalization and her need for close outpatient follow-up after discharge. Ensuring that the PCP is informed about his or her patient's hospital course and treatment as well as the plan for follow-up care establishes continuity of care between the inpatient and outpatient arenas. Effective communication between the hospitalist and the PCP is important not only at the time of discharge but also at the time of admission and throughout the hospital course. For example, at admission, a PCP can contribute valuable patient information to the inpatient care team, such as baseline functional status and patient preferences regarding treatment. During hospitalization, it is important to ensure that the PCP is kept informed at major decision-making points (eg, regarding invasive procedures or code status).

In addition to poor communication with the PCP, communication within the inpatient care team is again leading to needless re-work performed by the physician assistant, who must relay identical information to multiple members of the team. Approaching patient care and discharge planning in a multidisciplinary manner allows for all members of the team to have the most up-to-date information on the plan of care and to work more efficiently to ensure quality patient care.

Communication at Discharge

Mr. Irving works with Mrs. Woods on the technique for subcutaneous injection of anticoagulant medication. He then calls Dr. Cooper's office to arrange an appointment for Mrs. Woods in 3 days for anticoagulant adjustment. As Mrs. Woods' discharge papers are prepared, the case manager confirms that Mrs. Woods will receive today's dose of anticoagulant prior to her discharge, that the medication will be delivered to her home that afternoon, and that a home care nurse will visit her the following morning to draw blood for monitoring of her anticoagulation. Finally, Dr. Morales prepares a written summary of Mrs. Woods' hospital course and places it within the interdepartmental mail.

Two days after Mrs. Woods' discharge, Dr. Morales receives a message from Dr. Cooper. Dr. Cooper had been paged at home by Mrs. Woods' visiting nurse with concerns regarding the patient's warfarin dosage and a supratherapeutic INR result. Because Dr. Cooper had not yet received Dr. Morales' summary of Mrs. Woods' hospital course, she was unaware of the discharge dose of medication and the frequency with which blood tests were being followed when she received the call from the nurse. As a result, Dr. Cooper had a lengthy conversation with the visiting nurse, reviewing Mrs. Woods' in-hospital and postdischarge INR results and warfarin dose adjustments. In her message to Dr. Morales, Dr. Cooper requests that a full report of her patient's hospitalization be sent to her office via facsimile.

Using Systems to Provide Continuity of Care

As the team prepares to discharge Mrs. Woods, the systems that are in place to ensure continuity as her care transitions back to her PCP are overlooked. Dr. Cooper has received only a cursory review of Mrs. Woods' inpatient hospital course and has not been made aware of the changes to her medication regimen and the frequency of follow-up testing. A lack of a structured approach to relaying discharge information and systems to ensure the transmission of such information can prevent the delivery of vital information to providers who are resuming care of a hospitalized patient, namely the patient's PCP. In fact, previous work has suggested that PCPs are often not aware of tests that require follow-up upon hospital discharge [15–17]. This is particularly important

to prevent gaps in clinical knowledge that may occur at these transition points.

The responsibilities of the hospitalist do not end when the patient's discharge is decided. The hospitalist and his or her inpatient care team must ensure that all vital information regarding the patient's ongoing care plan is communicated accurately to the patient's outpatient physicians and other health care providers and guarantee that the appropriate follow-up is arranged. Seamless transition from the outpatient to inpatient care setting and from inpatient back to outpatient care relies on accurate communication among all who are involved in inpatient care as well as between the inpatient and outpatient teams.

Conclusion

As the hospitalist movement continues to grow in strength and numbers, it is important that core competencies for hospitalists be embraced as a vital skill set for hospital medicine. In this article, we demonstrate the importance of 1 of these core competencies—effective communication in the routine care of hospitalized patients. Effective communication during hospitalization includes communication with other health care professionals (eg, nurses, case managers, pharmacists) on the multidisciplinary team, with hospital staff and physicians at the time of hand-offs, with PCPs to ensure continuity of care, and with patients to educate and empower them as partners in their care plan.

The foundation of effective inpatient communication is built upon sound communication strategies. For example, use of a read-back/teach-back approach within the context of face-to-face communication helps to maintain open channels for the exchange of information between all members of the multidisciplinary team. A structured approach to relaying information between team members (eg, standardized hand-off processes, templates) helps to ensure transmission of all pertinent information in a specified order, so that omissions are avoided. In addition, ensuring that accurate and up-to-date information is passed between individuals improves continuity and thus quality of care [18]. Regardless of the players in the discussion, face-to-face verbal communication with interactive questioning allows for the most effective exchange of information. This dynamic is structured to allow for a read-back/teach-back relationship, which can further serve to guarantee information accuracy [19]. The incorporation of these strategies into the skill set of the hospitalist will not only improve the quality of information exchanged between the members of the multidis-

ciplinary team but also has the potential to directly impact and improve the quality of care delivered.

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