Learning Objectives

- Describe how to promote two-way communication with patients and health care professionals.
- Identify common barriers to verbal communication and describe ways to overcome each barrier.
- List at least six guidelines for documenting patient information in the medical record.
- State how to convey respect for patients.
- Identify patient situations that affect patient-pharmacist communication and suggest ways to deal with each situation.
- State how to communicate effectively with physicians, nurses, and other pharmacists.
- Identify skills for effective teaching, platform and poster presentations, and media interviews.

The ability to communicate clearly and effectively with patients, family members, physicians, nurses, pharmacists, and other health care professionals is an important skill. Some pharmacists are skilled communicators, comfortable with all types of people; other pharmacists find it difficult to communicate with health care providers in perceived or actual positions of authority or with patients from different socioeconomic or ethnic backgrounds. Fortunately, communication skills can be learned. One incentive for improving communication skills is that pharmacists with excellent communication skills and average pharmacy databases are more likely to be successful than pharmacists with poor communication skills and excellent pharmacy databases. Another incentive is that the inability to communicate effectively may harm patients. Poor communication between a pharmacist and a patient may result in an inaccurate patient medication history and inappropriate therapeutic decisions; may contribute to patient confusion, disinterest, and noncompliance; and may add to a patient’s frustration with the health care system. Poor communication between pharmacists and physicians, pharmacists and nurses, and pharmacists and pharmacists may harm patients if important information is not exchanged in an appropriate and timely manner.
VERBAL COMMUNICATION SKILLS

Essential verbal communication skills include the ability to listen, understand, and respond to what people say (active listening) and the ability to interpret nonverbal communication and respond in a way that encourages continued interaction (evaluation).

ACTIVE LISTENING

Focus on the patient, family member, or health care professional. Make that person feel like the center of attention. Convey an open, relaxed, and unhurried attitude. Set aside all professional and personal distractions and really focus on the person. Prevent or minimize interruptions (e.g., beepers, telephone calls, consultations).

Focus on the person and how he or she communicates (Figure 2-1). The tone and modulation of voice and number and placement of pauses may disclose how the person feels and may provide clues regarding the reliability of the patient-provided information. People who respond with a low level of energy, flat affect, and monotone voice may be depressed. People who respond to questions tentatively and hesitantly may be unreliable. Pauses may indicate that the person needs time to recall the information or find the right words or that the person is censoring the response or preparing to lie.

OBSERVATION AND ASSESSMENT

Effective two-way communication requires continual observation and assessment of how the other person is communicating. Body language and gestures provide important clues for the pharmacist, as well as the patient and health care provider.

![Figure 2-1](image)

Factors Influencing Communication.

Communication is affected by the integration of patient and pharmacist internal factors; sensory, emotional, and environmental factors; and verbal and nonverbal expression. (From Wilkins RL, Sheldon RL, Krider SJ: *Clinical assessment in respiratory care*, ed 2. St Louis, 1990, Mosby.)
Sit or stand at eye level, maintain eye contact, and use a focused body posture to convey interest and attentiveness. Sitting or standing at eye level or lower projects a nonthreatening, equalizing body position that facilitates open communication. Be physically close enough to the patient, family member, or health care professional for clear and comprehensible communication but do not intrude on the other person’s personal space. Invasion of personal space induces discomfort and may be perceived as physically threatening; in either case, communication is compromised.

Be aware of nonverbal messages. Certain gestures and postures provide clues regarding the other persons’ feelings (Table 2-1), although the clues are not always reliable. Change tactics to reengage the person if their body language indicates closure to communication.

**BARRIERS TO VERBAL COMMUNICATION**

**Physical Barriers.** Communication across or through physical barriers is extremely difficult. Physical barriers commonly encountered in community pharmacies include the large countertops and display areas behind which many pharmacists work, windows with security bars and protective glass, drive-through windows that isolate the pharmacist from the patient, and the elevated pharmacy work area that accentuates the pharmacist’s position of authority and places the patient in an inferior position.

Hospital and other institutional pharmacists have fewer physical barriers to contend with but have the additional problem of communicating with patients who are in bed. Patients in bed are easily intimidated by people standing over them. Interviews may be strained or limited depending on the patient’s level of discomfort. Make sure all conversations take place face to face at or below the patient’s eye level.

**Lack of Privacy.** Lack of privacy is a common communication barrier. Although lack of privacy often is identified as a barrier to effective communication with patients, it also is an important barrier when communicating with other health care professionals. Breach of privacy is possible whenever patient information is discussed. Do not discuss or debate nonspecific or specific patient data or health care issues in public areas such as hallways, walkways, elevators, cafeterias, libraries, and parking lots. Do not discuss patient-specific information with family or friends.

**TABLE 2-1**

<table>
<thead>
<tr>
<th>Gesture or Posture</th>
<th>Implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steepling of the hands</td>
<td>Confidence</td>
</tr>
<tr>
<td>Raising the hand</td>
<td>Desire to interrupt</td>
</tr>
<tr>
<td>Shifting body position</td>
<td>Desire to interrupt</td>
</tr>
<tr>
<td>Crossed arms</td>
<td>Shutting out the other person</td>
</tr>
<tr>
<td>Leaning toward the speaker</td>
<td>Receptiveness</td>
</tr>
<tr>
<td>Raising the hands and then letting them fall limply</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>Frequent throat clearing</td>
<td>Disagreement</td>
</tr>
</tbody>
</table>
Lack of privacy is a common problem in most health care settings. Few community pharmacies have private counseling areas. Most hospitalized patients have at least one roommate; three or more patients may share some hospital wards. The lack of privacy makes the voicing of personal concerns and the exchange of accurate and complete information difficult for many patients. Given a choice, patients may withhold potentially embarrassing personal information or avoid asking potentially embarrassing or “stupid” questions if they think the conversation may be overheard.

Provide as much privacy as possible. Ideally, converse with patients and discuss patient-specific information with other health care professionals in private counseling or consultation rooms. If physically separate space is not available, converse in a space that is as private as possible. In community pharmacies, converse with patients in a corner of the pharmacy away from the cash register, drop off windows, and pick up windows. In hospitals and other institutions, create a sense of privacy by closing the door to the room and pulling the curtain around the bed. Ambulatory institutionalized patients may be able to walk to nearby conference rooms, private consultation rooms, or vacant waiting rooms.

The Telephone. The telephone is an important communication tool used to communicate with patients, patient family members, physicians, nurses, other pharmacists, and other health care professionals. Speak clearly, listen carefully, be organized, and state facts clearly and calmly.

Those initiating the telephone conversation should identify themselves by name and state the purpose of the call. For example, when calling a physician office, say “Hello. This is Joan Arnold. I’m the pharmacist working with Mrs. Johnson. I have a question about Mrs. Johnson’s diabetic drug regimen. May I please speak with Dr. Rivers?” Be prepared to repeat the request several times before being connected to the right person. Stay patient and tolerate and expect to spend some time waiting on hold.

When answering telephone calls, identify yourself and ask for the caller’s identity. Make every effort to deal with the call immediately; avoid putting the other person on hold. If too busy to speak with the caller at that moment, explain the situation to the caller immediately and arrange to call back at a mutually convenient time rather than placing the person on hold. Most telephone calls are directly related to patient care and need to be dealt with as soon as possible. Interruptive telephone calls should be dealt with as unhurriedly and professionally as possible.

Pharmacists sometimes receive telephone calls from angry and upset patients, patient family members, nurses, physicians, and other health care professionals. The best way to deal with these types of calls is to stay calm, listen to what the person has to say, clarify the issue, and then handle the problem as calmly and coolly as possible. Nothing is accomplished if both parties let their emotions rule the interactions.

**WRITTEN COMMUNICATION SKILLS**

Pharmacists must be able to accurately and effectively document patient information in the patient medical record, document patient information in pharmacy medication profiles and other pharmacy records, and correspond with patients and other health care professionals. Many pharmacists routinely document written drug information responses; this skill is discussed in Chapter 9.

The patient medical record is the primary written communication tool for all health care professionals. Health care professionals who care for patients in the inpatient setting write daily progress notes in patient charts. Professionals in the outpatient
setting write progress notes after each patient visit. Writing in a patient medical record (charting) is a privilege granted by each institution or organization to individual health care professionals. Many institutions and organizations grant pharmacists charting privileges, although this practice is far from universal.

The medical record ordinarily is used to document and communicate information about the patient’s progress; to assess, usually retrospectively, the quality and appropriateness of patient care; and to document patient care activities and services for remuneration. Health care professionals must adhere to legal, ethical, and professional standards when documenting patient information (Box 2-1). Black ink is photocopied more clearly than other colors and is recommended just in case the patient record has to be photocopied (e.g., subpoenaed for a legal hearing or forwarded to health care professionals outside the institution or practice). Clear photocopies reduce the risk of misreading or misinterpreting the documented information. Clear and legible handwriting is important. Errors are dealt with by crossing out the error with one line and initialing the error (e.g., mistake). This format clearly documents the error and identifies the individual who changed the record. Products that paint over typewritten or handwritten information are not used on legal documents because they hide the error and could be used by anyone at anytime to change the record.

Document factual information and restrict assessments and judgments to those appropriate for pharmacists. For example, a pharmacist may learn during a patient medication history interview that the patient drinks a fifth of whiskey and a six-pack of beer daily. It is appropriate to document the facts but inappropriate to label the patient an alcoholic.

Every note in the patient medical record contains a descriptive heading (e.g., clinical pharmacy, pharmacokinetics, nutrition support, attending, cardiology consult), the date and time the note was written, patient-specific data and other information, and the signature and title of the health care professional. The heading identifies the type of information found in the note and enables individuals using the chart to scan the pages quickly when searching for specific information. The date and time are important details that put the information in context with other patient-related data and information. For example, a pharmacist may assess a patient and make drug and dosing recommendations before that day’s laboratory results are available. Knowing the time of the recommendation allows the other members of the health care team to accept or reject the recommendation in context of the most up-to-date patient data. The content of the note is organized using a SOAP format (Subjective, 

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**BOX 2-1**

**Guidelines for Writing Medical Record Notes**

1. Use black ink.
2. Write clearly and legibly.
3. Label notes with specific descriptive headings.
4. Provide the date and time on the notes.
5. Document the facts and avoid making unsubstantiated judgments.
6. Organize the information using the SOAP or freestyle format.
7. Sign the note with name and title.
Objective, Assessment, Plan) or a freestyle format. The SOAP format is a universally recognized structured format (see Chapter 7), whereas a freestyle format has no accepted organizational structure. The health care professional writing the note signs the note. Documents or notes written by students and other nonlicensed trainees are cosigned by the licensed professional who is supervising the nonlicensed individual.

Most institutions, outpatient clinics, and individual practices are transitioning from handwritten charts to electronic charts. Data are entered using bedside computer terminals or any computer in the system, eliminating “competition” for the written chart. Electronic charts limit access to confidential patient information to individuals with approved passwords but expand access to the charted information by allowing entry from any computer within the system. The computer automatically labels the data with the date and time and the name of the person linked to the password.

INTEGRATION

COMMUNICATING WITH PATIENTS

Effective communication between pharmacists and patients or family members is extremely important to pharmaceutical care. Ineffective communication leads to confusion and misunderstanding and may contribute to inappropriate decisions regarding drug therapy.

Patient Titles. Unfortunately, most health care professionals automatically address patients by their first names, even when meeting patients for the first time. Some patients take offense at being addressed by their first names, especially if they are much older than the health care professional. Health care professionals who automatically expect patients to address them by title compound the offense. This expectation puts the patient in an unequal and inferior position and is a throwback to the days of paternalistic health care attitudes. Some patients offended by being addressed by their first names may openly express their displeasure. Other patients may be so put off by this behavior that they are unwilling to engage in productive conversation.

Common courtesy dictates that patients be addressed by appropriate title (e.g., Mr., Mrs., Ms., Rev., Dr.). However, use the correct title. Do not assume that all adult women are married or, if married, wish to be addressed as “Mrs.” Conversely, do not assume that all adult women, married or single, want to be addressed as “Ms.” The best way to avoid confusion is to ask each patient how he or she wants to be addressed. Saying “Hello. My name is Dr. Smith. Do you wish to be called Ms. or Mrs. Sandborne or would you prefer to be called Elizabeth?” requires very little time or effort. This approach conveys a sense of respect for the patient, allows the patient to express their preference, and indicates to the patient how to address the health care professional. The one exception to this approach is in addressing disoriented, confused, or sedated patients; these patients usually respond better to their first names than to their titles.

Respect for the Patient. Display a genuine respect for the patient. Respond to the patient as a person, not a prescription or case (e.g., “The asthma patient in room 1012”). Maintain a professional relationship and avoid exchanging personal information
and confidences with the patient, remembering, “An interview is a conversation with a purpose rather than a conversation with a potential friend.”

Respect for the patient is conveyed by acknowledging, without judgment, patient-specific attributes that may be different from the pharmacist’s value system or even offensive to the pharmacist. Attributes such as smoking, excessive drinking, use of illicit drugs, self-destructive behaviors, nonadherence to prescribed regimens, deficient hygiene, and gross obesity may be offensive but must be dealt with nonjudgmentally. Other patient-specific traits such as beliefs in folk physiology or use of alternative remedies or unorthodox medical treatments also must be acknowledged without judgment. Pharmacists also must be able to acknowledge differences in socioeconomic backgrounds and ethnic origins without passing judgment.

Respect for the patient is conveyed by pharmacist’s attitude (Box 2-2). Arrange adequate time for patient interaction and minimize interruptions from phone calls, beepers, and other patients or health care professionals. Introduce yourself, obtain permission to interact with the patient, and explain the purpose of the interaction. Explain who will see the information obtained by the pharmacist and how the information will be used. Pharmacy students need to clearly identify themselves as students and explain who will see information obtained during the student-patient interaction and the way in which the information will be used (e.g., for teaching purposes, for patient care, for research).

The environment established by the pharmacist conveys respect for the patient. The physical environment should be clean, neat, and well organized. Make sure the patient is as comfortable as possible and provide as much privacy as possible (refer to the Barriers to Communication section later in this chapter). Remove as many barriers to communication as possible (refer to the Barriers to Communication section later in this chapter). Note taking during the patient interaction is acceptable but should not control the interaction.

**Questioning Techniques.** The pharmacist, not the patient, controls the patient-pharmacist interaction. The pharmacist controls the interaction by controlling the types of questions asked and the time allowed for patient response. Controlling the interaction does not mean, however, that the pharmacist should fire off a rapid sequence of yes/no questions or abruptly cut off patient response. Questioning skills improve as the pharmacist gains experience interacting with a variety of patients, including pleasant and not so pleasant, cooperative and uncooperative, verbose and recalcitrant, and interested and disinterested patients.

**BOX 2-2**

**Behavioral Checklist**

- Be relaxed, confident, and comfortable.
- Show interest in the patient.
- Maintain objectivity.
- Be nonjudgmental.
- Be sincere and honest.
- Maintain control of the interview.

Early in the interview, ask open-ended questions that allow patients to talk freely about their medications and concerns. This technique clues the patient that the pharmacist is interested in what he or she has to say and gives the pharmacist feedback regarding the patient’s level of knowledge and ability to communicate this information. A good initial question for both acute care and chronic care patients is, “What medications are you currently taking?” Use minimal facilitators such as “yes,” “uh huh,” and “what else?” and provide nonverbal encouragement by smiling and nodding when appropriate. Give the patient time to answer. Some patients can provide well-organized and detailed information without much additional direction; however, other patients ramble and shift to nonrelated topics. Some patients cannot provide any information without specific targeted questions. Some patients have told their story so many times that they automatically recite their story or what they think the pharmacist wants to hear without focusing on the pharmacist’s questions.

Ask directed and structured questions after the patient has presented his or her story or has begun to stray from the initial question. Narrow the focus of the question as appropriate. Discuss one topic at a time and avoid asking leading questions, multiple questions, and yes/no questions. Simple yes/no questions are useful screening questions but inhibit the patient’s flow of information when used excessively.

Take time during the patient interaction to summarize the information provided by the patient. This lets the patient know what the pharmacist has learned, gives the pharmacist a chance to verify the information, and ensures that the patient and pharmacist are in agreement. Frequent summaries also let the pharmacist identify and correct any discrepancies in the patient’s story.

Close the patient-pharmacist interaction by providing a final summary of the information obtained from the patient. Let the patient make any final clarifications or add additional information. End the interaction by thanking the patient pleasantly and say “good-bye.”

**Patient Instruction.** Pharmacists tend to consider the prescription label the primary communication tool between the pharmacist and the patient. However, optimal patient interaction requires more than this one-way communication tool. Several communication objectives for patient instruction have been identified, including identification of the patient’s needs, control of the timing and amount of information provided during each interaction, determination of patient-specific objectives, and assessment of patient learning. For example, the pharmacist cannot assume that asthmatic patients use metered-dose inhalers correctly or know how to monitor their lung function with a peak flow meter. Question such patients to determine their depth of knowledge and degree of understanding; then develop a plan for patient education. Plan to convey drug-specific information over several sessions and provide such patients with written information to reinforce the verbal information.

Assess patient needs in the context of the patient’s emotional status, educational background, and intellectual ability. Some patients want to know everything about their medication. Other patients do not want to know anything. Balance the patient’s desire for information with the need for information. At the end of the interaction determine the depth of the patient’s learning and retention in a non-threatening manner. Ask the patient to summarize or repeat the information discussed. Over time and through repeated interaction, the pharmacist can convey a large amount of drug-specific information and help the patient successfully manage the medication regimen.
Medical Jargon. Avoid medical jargon when communicating with patients. This can be challenging, but pharmacists must be able to translate commonly used pharmacy and medical terms into lay terminology. Results from a study evaluating patient understanding of commonly used pharmacy terms (Table 2-2) indicated that many patients did not understand these terms; in fact, many patients interpreted these terms quite differently than they were intended.5 For example, some patients thought the term diuretic meant a medication for diarrhea or concerned the diet or diabetes; some patients thought the term generic meant synthetic or not as good or thought the term concerned the elderly.

Patients misinterpret even commonly used medical terms. For example, the term hypertension has multiple meanings to patients. Some patients think it means hyperactive or nervous. Some cultures use the term high blood to indicate hypertension and low blood to indicate anemia. Other terms, such as angina, divided dose, anticoagulant, sublingual, subcutaneous, intravenous, and dyspnea, may have no meaning whatsoever for the typical patient.

The best way to avoid miscommunication and confusion is to speak in plain English and use concrete and specific references. Provide many opportunities for patients to ask questions. Be especially sensitive to the needs of nonnative English speakers who may be confused by American slang or cultural references. Use translators for patients who do not speak or understand English. Be aware that some patients, especially those with chronic disease, frequent contacts with the health care system, or a health care background, may have sophisticated pharmacy and medical vocabularies and may be offended by the use of simplified lay terminology.

Special Situations. Pharmacists must be able to communicate with patients who are unable or unwilling to communicate along generally accepted societal norms. The patient’s situation or attitude may compromise communication. Some patients are
so stressed by acute or chronic illnesses that they do not adhere to common rules of courtesy. Communication with such patients may be extremely difficult. Differences in ethnic, social, and educational backgrounds may make communication between the patient and pharmacist difficult. The pharmacist, not the patient, is responsible for recognizing the special situation and having the skills and flexibility necessary to ensure appropriate and effective communication.

**Embarrassing Situations.** Most patients find discussions related to sex, intimate body parts, and bodily functions embarrassing (Box 2-3). Many female community pharmacists have had the experience of watching men loiter in the pharmacy until they can ask a male clerk about condoms. Asking male pharmacists about the application of vaginal creams or suppositories embarrasses many female patients. Some patients are so embarrassed by such situations that they deliberately avoid asking for help, choosing to remain uninformed rather than risk the embarrassment (Figure 2-2).

To deal with these situations, be aware of what may be potentially embarrassing and be ready to bring up the subject if the patient has difficulty doing so. Converse with the patient in as private an environment as possible. Be sensitive to clues that suggest potential embarrassment and communicate with patients in a respectful, professional manner.

Clues to a patient’s embarrassment include avoidance of eye contact, blushing, stammering, closed body language, and excessive nervous small talk about unrelated matters (e.g., the weather, sports). Project a professional demeanor and put the patient at ease by discussing the issue in a straightforward, scientifically appropriate manner. Humor, which may temporarily relieve tension, may make the patient more embarrassed and should be avoided. Use anatomically correct terms instead of slang. Give patients many opportunities to express their feelings.

**Mute Patients.** Muteness from endotracheal intubation, tracheostomy, or damage to the vocal cords or trachea from disease or trauma can be extremely frustrating
for patients. The situation can be equally frustrating for pharmacists, who rely on verbal information from patients when obtaining patient information and monitoring response to therapy. Written communication and point and spell letter boards can be time-consuming but often are the only means for two-way communication. Encourage these techniques and allow sufficient time for adequate communication. In addition, maintain your end of the conversation and do not limit your verbal responses just because the patient is mute.

**Elderly Patients.** Elderly patients have special needs. Elderly patients may have impaired hearing and vision. The hearing loss associated with aging is characterized by loss of ability to distinguish between high-frequency sounds, making it difficult for patients to distinguish between conversational tones and background

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**Figure 2-2**

**Embarrassing Situations.**

Some patients are so embarrassed by their situations that they choose silence rather than public disclosure.
noises. Visual changes associated with aging include loss of accommodation, cataracts, reduced peripheral vision, and problems distinguishing some colors. Elderly patients may be sensitive to harsh, glaring lights and highly reflective surfaces. They may not be able to read prescription labels and other printed material or distinguish among similarly shaped dosage formulations.

Take the time to engage elderly patients in unhurried conversation. Speak slowly, distinctly, and avoid youth-oriented vernacular or slang. Treat elderly patients with respect. Do not assume that every elderly person has impaired hearing. Speak directly to the patient and do not assume the patient is incompetent or that the person accompanying the patient is a caregiver or guardian. Use large-print labels and printed materials and reinforce written information with verbal communication. Touching the patient lightly on the arm or shoulder may reassure the patient and reinforce the context of the conversation.

**Pediatric Patients.** Communicate directly with the pediatric patient as well as with the parent or guardian; do not assume that children have nothing to contribute to their health care. Even young children can understand why they are taking a medication and can begin to develop a professional relationship with the pharmacist. However, information must be age appropriate. For example, communication with young children may be as simple as telling them why they are going to take the medication (e.g., “This medication will help you breathe better”). In-depth information exchange is appropriate for many preteens and teenagers. Direct communication with preteens and teenagers who have chronic disease for which they follow chronic medication regimens is especially important. Preteens and teenagers exert considerable control over their lives and need to understand how to use their medications.

**Physically Challenged Patients.** Physically challenged patients often have to deal with multiple communication barriers. Pharmacists, like most members of society, often have a hard time focusing on the person in the wheelchair or seeing the patient behind the prosthetic device. Many people falsely assume that physical disabilities are linked with mental disabilities. In addition to these perceptual difficulties, some physical disabilities leave the patient with limited or garbled speech, making it difficult for the patient to express himself or herself. Other disabilities impair a patient’s vision or hearing.

Communicating with physically challenged patients is no different than communicating with physically able patients. Engage the patient in unhurried conversation and give the patient ample time to respond. Speak directly to the patient and do not assume that the patient is incompetent. Do not assume that the person accompanying the patient is the patient’s caregiver. Do not stare at the patient or avoid eye contact and do not physically assist the patient (e.g., push a wheelchair, guide a blind patient) unless invited to do so by the patient.

**Mentally Retarded Patients.** Communicate clearly and directly with mentally retarded patients and do not assume that the patients are incapable of participating in their health care. Look beyond the disability and deal directly with the patient. However, communicate clearly and directly with the patient’s caregiver. Many degrees of mental retardation are possible; be flexible enough to assess the level to which each patient can participate and communicate appropriately for each situation.

**Hearing Impaired Patients.** Be sensitive to the potential for patients to have hearing impairment. Do not assume that all people with hearing impairment can read lips or understand American Sign Language (ASL); also do not assume that a hearing aid returns the patient’s hearing to normal. Do not assume that hearing impaired patients have diminished intellectual abilities.
Many pharmacists are quite skilled in ASL, used by the Deaf in the United States and English-speaking Canadians, or they can finger-spell words using the ASL alphabet. ASL courses and seminars are widely available. Regardless of the level of special skills obtained, communicate as clearly as possible with hearing impaired patients. Verbalize slowly and distinctly; minimize background noise. Face patients who can read lips and avoid turning away from the patient during the conversation. Written communication may be necessary for two-way communication.

**Critically Ill Patients.** The intensive care unit is a highly depersonalizing environment. Patients have little privacy or sense of control. Families and friends may feel overwhelmed. Patients are surrounded by high-tech equipment and may be sleep deprived; drowsy from pain medication; or uncomfortable from procedures, tests, or surgery. This environment makes it difficult to relate to the patient as a person. Nevertheless, it is important to communicate directly with the patient. Speak to the patient when entering or leaving the patient’s room, even if the patient appears unresponsive. Never assume that the patient cannot hear or comprehend what is said in his or her presence. Make eye contact with the patient, even if it means getting very close to the patient’s face. Endotracheal intubation renders patients mute but do not assume that intubated patients cannot communicate. Intubated patients can respond to yes/no questions by blinking their eyes or raising an arm. Some intubated patients can express themselves in writing if the paper is positioned for them or use point and spell boards. Acknowledge and communicate directly with the patient’s family and friends, who may be very anxious or frustrated.

**Chronically Ill Patients.** Chronically ill patients present unique communication challenges. Chronically ill patients may be sophisticated and/or demanding health care consumers. Some chronically ill patients know more about the management of their disease than many health care professionals; this situation may be threatening for the pharmacist. Some chronically ill patients may be completely disillusioned by repeated unsatisfactory interactions with the health care system and may be bitter, cynical, and difficult to engage in conversation.

Chronically ill patients deserve the same amount of information and attention as all other patients. Assess the needs of each patient and be flexible enough to communicate on an appropriate level. Discussing sophisticated therapeutic regimens may be a pleasure with pleasant and well-informed patients but extremely difficult with bitter, cynical patients. Chronically ill patients must learn to live with their disease; this may take years and may never be fully accomplished.

**Terminally Ill Patients.** Terminally ill patients may be sophisticated and/or demanding health care consumers as well; they also may be bitter, cynical, and difficult to engage in conversation. Terminally ill patients often take complicated drug regimens requiring detailed instruction and monitoring. Many terminally ill patients and their families have to deal with the stigma of frequent prescriptions for high-dose narcotics.

Treat terminally ill patients with respect and work with them to achieve optimal therapeutic efficacy within the complexities of their illnesses and the health care environment. Terminally ill patients may need help dealing with complex insurance paperwork and complex medication regimens. Terminally ill patients need close monitoring and reassurance about their medication regimens. Some terminally ill patients require large and frequent doses of narcotics; work with the patient and their family to legitimize the use of these medications and minimize the hassles associated with obtaining narcotics.
Hard-to-Reach Patients. Hard-to-reach patients include those of low socioeconomic status, minorities, and illiterate persons. Communicating with these patients may be difficult. Patients of low socioeconomic status have few resources to deal with health care issues. They may have little knowledge about health care in general and their own health in particular and may have different coping mechanisms and expectations. They may not have the economic or social resources to participate in preventive health care or manage acute or chronic illness. Pharmacists must be sensitive to these issues.

Look beyond these issues and communicate clearly and directly with each patient as an individual, regardless of the patient’s status. Hard-to-reach patients deserve as much respect, time, and information as do all other patients and should not be glossed over and dismissed because of their socioeconomic status, ethnic origin, or illiteracy. The health care needs of hard-to-reach patients often are greater than those of other patients; be sensitive to their needs. Help illiterate patients organize complex medication regimens by using different-sized bottles for each medication or color-coding the labels. Calendars with dosages of unit-of-use medication stapled to the appropriate date may help illiterate patients adhere to complex medication regimens. Other medication-delivery devices may help patients keep track of their doses.

Be sensitive to the cost of medications and the ability of the patient to pay for the medication. Low-income elderly patients in particular may be too embarrassed to ask about the cost of medications and may accept expensive medications they cannot afford. Less expensive, therapeutically acceptable alternative medications usually are available. Some pharmaceutical companies have patient assistance programs that provide select medications free of charge to individuals without third-party prescription coverage and who meet specific income requirements.

Antagonistic Patients. Antagonistic patients do not want to be bothered with medication histories, interviews, or other pharmacist-patient interactions. The natural response to these patients is to leave them alone and avoid them if possible. However, these patients deserve as much attention as other patients and may need more attention from the pharmacist because their behavior alienates them from other health care professionals. The best ways to deal with such patients are to be as professional and direct as possible and limit the length of the interaction to as short a period as possible. These patients may be frightened or simply fed up with the entire health care system; therefore clarification of the purpose of and reasons for the interaction and the ways in which the information obtained from the interaction are used may be helpful. Most patients have a great deal of respect for pharmacists and cooperate if the need for the interaction is clearly defined and they perceive that they are treated with respect.

Noncommunicative and Overly Communicative Patients. Noncommunicative and overly communicative patients present special challenges. Noncommunicative patients never volunteer information or express much interest in anything anyone has to say. These patients answer all questions with unenthusiastic yes/no responses. To facilitate communication, get the patient talking about any topic and then ask simple, open-ended questions that will provide at least some of the information being sought during the interaction. For example, patients unwilling to identify the medications they are currently taking may open up and start discussing their medication if asked to describe their satisfaction with past medication. Sometimes no communication method works and the communication remains one way. However, most patients can be drawn out and encouraged to engage in effective two-way communication.
Overly communicative patients digress when asked even simple direct questions. Pharmacists eventually obtain the information being sought, but only after investing a lot of time in the interview. The best way to deal with this type of patient is to take firm control of the conversation from the start and redirect the patient when he or she wanders off the subject. The patient may have to be allowed to wander a little before being gently but firmly interrupted and redirected. For example, a patient may be eager to discuss a pet dog’s medical problems. The pharmacist may need to give the patient a few moments to talk about these issues before redirecting the patient back to the focus of the interview.

COMMUNICATING WITH HEALTH CARE PROFESSIONALS

Effective communication between pharmacists and physicians, nurses, and other pharmacists is essential. Poor communication not only leads to frustration and lack of respect among professions but also may compromise patient care if important information is misunderstood, ineffectively conveyed, or left out.

Pharmacist-Physician Communication. Pharmacists and physicians often have trouble communicating with one another. Both professionals are extremely busy; communication usually takes place when neither party has much time to converse. Many pharmacists are intimidated by physicians (Figure 2-3). Pharmacists must be comfortable with their role on the health care team and confident in their unique knowledge and contributions to patient care.

Be prepared with specific questions or facts and recommendations when initiating a patient care–related conversation with physicians. Make sure other resources cannot answer the question. Stay within the pharmacist’s area of expertise. Choose the right time and place for the conversation. Never interrupt a physician-patient interaction, except for life-threatening situations. Follow the chain of command. Do not go to an attending physician when the question or recommendation is more appropriate for a less senior member of the medical team. Do not interrupt teaching rounds with trivial questions and observations better communicated one-to-one with individual physicians. Do not engage physicians in lengthy social small talk.

If the physician initiates the conversation, listen carefully, assess the information or question, and ask for additional information until the question is clear and specific. Physician-initiated questions often are vague and general. Clarify the question and obtain appropriate patient-related data. For example, a physician may ask if a serum digoxin concentration of 0.8 µg/L is okay. Given that the usual therapeutic range is 0.8 to 2 µg/L, the initial instinct is to verify that a concentration of 0.8 µg/L is okay. However, the question should not be answered until the pharmacist finds out when the blood sample was obtained, when drug therapy was initiated, why the drug was prescribed, the clinical status of the patient, and the goal of therapy.

Pharmacist-Nurse Communication. Pharmacists and nurses often have trouble communicating with one another. Pharmacists and nurses are extremely busy; communication often occurs when neither party has much time to spend conversing. Unfortunately, most pharmacist-nurse communication takes place because of drug distribution errors; much of the tension between the two professions is based on these interactions. Nurses are pressed to obtain and administer medication, and pharmacists are frustrated because nonstat requests often are presented as emergencies (e.g., stat docusate sodium). The pharmacist and the nurse end up in a tug-of-war over work priorities, which can lead to lack of respect and poor communication on
the part of both professionals. Pharmacists and nurses must treat one another with respect; both professionals must realize that they share the same goal (e.g., optimal patient care) and are on the same patient care team. Communication should be clear, to the point, and timely.

An added barrier to effective pharmacist-nurse communication is the use of the telephone as the primary means of communication. It is easy to be rude, either intentionally or unintentionally. Feelings get hurt and reputations lost when tempers flare during less-than-optimal telephone interactions.

**Pharmacist-Pharmacist Communication.** Patient care may be less than optimal because of communication difficulties between pharmacists. For example, pharmacists on consult services such as pharmacokinetics or infectious disease may not have access to recent uncharted patient information or be privy to in-depth discussions during team rounds. Pharmacists on the patient care team need to update consulting pharmacists frequently. Consulting pharmacists should be aware that the primary team may have more information than that documented in the patient record; they should not make recommendations in isolation.
Inpatient patient-focused care takes place 24 hours a day, 7 days a week. Continuity between shifts requires clear communication of patient information, plans for the patient, and other patient issues. A common communication system is the exchange of patient information during sign-out rounds or the discussion of patient-specific issues and the passing on of patient monitoring forms and other types of written documentation between the pharmacists leaving the service and those assuming responsibility for the patient.

Community pharmacists and institutional pharmacists rarely share patient-related information. Although patients and other members of the health care team potentially benefit by knowing details regarding patient’s medications and status before hospitalization and upon discharge, the fragmented nature of traditional health care delivery systems makes this type of communication nearly impossible. Unified health care delivery systems may allow for more information to be communicated among pharmacists as patients move between ambulatory and acute care environments.

**ADDITIONAL COMMUNICATION SKILLS**

**TEACHING**

Many nonfaculty pharmacists teach in a variety of settings, including one-on-one individualized patient teaching, small group patient support groups, and seminars and lectures for pharmacy and other health care students. Community, institutional, and industry pharmacists may have a variety of classroom teaching responsibilities at nearby colleges of pharmacy, nursing, or medicine (e.g., lectures, recitations, laboratories). Although many pharmacists teach, most have little formal training.

A teacher must be well organized and knowledgeable about the subject being taught and must be an excellent communicator. Communication is enhanced by having good organizational skills. The structure of the session and material should be obvious without the use of written handouts. Introduce topics and summarize periodically. Interact with the audience during the teaching session to determine the depth of the participant’s understanding and change or redirect the focus of the lecture or discussion to meet the needs of the audience. Direct questioning and assessment of responses are easy ways to determine whether the students and participant understand the material; however, these methods are less effective in large classroom settings. Feedback in formal classroom settings comes primarily from nonverbal behavior. Participants who understand and comprehend the material are quiet, focused, and obviously thinking. Participants who are confused or do not understand the material being presented shift uneasily in their seat, converse with those around them, engage in other activities (e.g., reading a newspaper), or sleep.

Pharmacy clerkships typically consist of one-on-one or small group teaching sessions. The student and teacher review individual patient cases and discuss the pathophysiologic and therapeutic issues. Many students are intimidated by the highly individualized nature of this type of one-on-one teaching. Put the student at ease while controlling the educational aspect of the interactions. Students also may feel intimidated or threatened by a constant barrage of seemingly unrelated questions. An effective communication tool during these types of teaching sessions is the circular questioning technique. This technique involves guiding the student through a series of related, basic questions that eventually lead the student to discover the
correct answer to a previously asked question. Then ask a series of increasingly difficult questions, allowing the student to reinforce the material already learned while applying and learning new information. Frequent verbal summaries and constructive feedback are essential teaching tools.

**PLATFORM AND POSTER PRESENTATIONS**

*Platform Presentations.* Many pharmacists make platform presentations at local, state, and national professional meetings. However, most pharmacists have little experience with these types of presentations. Audiences range from less than a dozen people to several hundred and include pharmacists as well as other health care professionals. Many pharmacists are stressed by public speaking. Although the degree of stress felt by the speaker depends on the individual and the specific situation, some degree of stress is perfectly natural. Stress is reduced through experience and thorough preparation. However, many experienced speakers still admit to being nervous before and during presentations. Some speakers find they can reduce stress by acknowledging the anxiety rather than denying their feelings. The nervous energy generated by stress can be directed into enthusiasm for the topic and increased energy during the presentation.

Reduce stress by selecting an appropriate topic. Speaking about a familiar topic is much easier than speaking about a less familiar topic. Be well informed and well prepared. Minimize stress by considering the audience and targeting the level of information to the audience’s background. This helps create interest on the part of the audience, which in turn provides positive feedback to the speaker. Learn how to operate all the audiovisual equipment before starting the presentation. Reduce the stress of answering audience questions by anticipating and preparing answers to likely questions.

Use appropriate audiovisual materials. A good visual image presents information more vividly and accurately than lengthy verbal descriptions. For example, a videotape of a patient having a grand mal seizure provides visual images that cannot be obtained from oral descriptions. Create well-designed slides (Box 2-4), transparencies (Box 2-5) and audio tapes. Currently available computer programs enable creation of sophisticated images and integration of multiple audiovisual formats. Design visual images to enhance rather than replace orally presented information. Design the images so that all members of the audiences can see the images and read all the information presented.

**BOX 2-4**

**Slide Design**

*Use simple font styles.*
*Limit each slide to one idea, figure, or table.*
*Use a horizontal rather than a vertical format.*
*Use no more than 5 or 6 lines per slide.*
*Use a 2-to-3 horizontal/vertical ratio for each slide.*
*Use colors to highlight information, but do not use more than 2 or 3 colors.*
*Use bright, clear colors; avoid pastels and neon colors.*
*Use simple tables and graphs.*

*Electronic slides and 35-mm slides.*
Poster Presentations. The poster presentation is a unique communication format in which the information is displayed rather than orally presented. Although most poster sessions require the author to be available to answer questions and discuss the information presented, the visual image of the poster is what grabs the attention of passersby and draws them in for more detailed perusal. Posters that attract the most attention have clear, descriptive titles and a colorful, neat, and professional appearance.

The allocated space dictates the amount of information presented in the poster. The amount of space allocated for each poster varies from meeting to meeting; requirements and limitations are communicated to the presenter when the poster is accepted for presentation. Most posters include a descriptive title, names of the individuals presenting the data, abstract, introduction, background information, study design, data, results, and conclusions. Printed material should be readable from several feet away. Brightly colored backgrounds enhance the visual presentation. Visual aids such as tables, graphs, charts, and photographs communicate information more effectively than multiple pages of text.

MEDIA INTERVIEWS
Pharmacists may be called by the media to provide background information regarding therapeutic issues such as the marketing of an important new drug, a widely publicized drug-related problem, or the withdrawal of a drug from the market. Media interviews can be interesting and rewarding experiences that provide a positive and effective form of communication between pharmacists and the public. However, pharmacists need to remember that journalists are not health care professionals and may misunderstand or use information out of context. Be cognizant of the very short deadlines most journalists have to meet; journalists may need information for a news report scheduled to air in just a few hours. Journalists can be quite aggressive. A media expert noted, “If you don’t learn to use the media to your advantage, you will be used by it.”

Most media contact is by telephone. Determine the contact’s name, telephone number or e-mail address, organization, position, how the information is going to be used, and the exact issue of interest. Do not answer any questions, divulge any information, or provide any opinions without knowing this information. Some members of the less-than-reputable media do not offer this information unless specifically prompted. Members of the legitimate media understand the importance of this information and readily disclose these facts.

Prepare to speak with a journalist by reviewing the subject to be discussed. Anticipate related or tangential issues and be prepared to elaborate on the topic and to

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<th>BOX 2-5</th>
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<td><strong>Transparency Design</strong></td>
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- Use simple font styles.
- Use letters large enough to be read from a distance.
- Limit each transparency to one idea, figure, or table.
- Use no more than 5 or 6 words per line.
- Use no more than 5 or 6 lines per transparency.
explain technical terminology and concepts in lay language. Speak with other individuals who have been interviewed by the reporter or read articles published by the journalist to get a feel for the person’s style. After the interview, ensure that the information obtained by the journalist is accurate. No one wants to be misquoted or quoted out of context. Be available for clarification by telephone, fax, or e-mail. Some print-format publishers ask sources to review and verify the information before publication.

MANUSCRIPTS

Original research reports, case studies, review articles, editorials, and letters to the editor are important communication tools among health care professionals worldwide. Publishing these types of articles in the print media is an important but challenging activity. Successful publication requires excellent writing skills as well as careful planning and execution of the plan.

One of the most important decisions made when attempting to publish a manuscript is selecting the appropriate journal. Match the focus and type of manuscript with the focus and audience of the journal. For example, editors of the *Journal of Infectious Diseases* are not interested in publishing a manuscript about a drug used to treat gastrointestinal bleeding. Other common mistakes include trying to publish information already well documented in the literature, submitting a poorly designed and/or executed study, submitting a poorly written manuscript, and not following journal-specific guidelines. Well-written manuscripts that meet the needs of the journal’s audience will be published.

**SELF-ASSESSMENT QUESTIONS**

1. Active listening consists of which of the following tasks?
   a. Focusing on what the other person says
   b. Assessing the way the other person communicates
   c. Conveying an open, relaxed, and unhurried attitude
   d. All of the above
   e. None of the above

2. To convey interest and attentiveness, the pharmacist should do which of the following?
   a. Avoid eye contact.
   b. Stand or sit at eye level or lower.
   c. Stand or sit as close to the person as possible.
   d. Ignore the other person’s body language.
   e. Take copious notes during the interview.

3. Barriers to verbal communication are minimized in which of the following settings?
   a. The interview takes place through a window with security bars.
   b. The interview takes place in front of three of the patient's hospital roommates.
   c. The interview is conducted over the telephone.
   d. The patient is interviewed in a private consultation office.
   e. The patient is interviewed through a drive-in window.

4. Which one of the following is not an important consideration when writing medical record notes?
   a. Use black ink.
   b. Write clearly and legibly.
   c. Title the note with a specific heading.
   d. Document the facts and avoiding unsubstantiated judgments.
   e. Begin the note on an unused page.
5. When is addressing a patient by the first name appropriate?
   a. When a patient is disoriented
   b. When meeting a patient for the first time
   c. When trying to placate a patient
   d. When a patient is much older than the pharmacist
   e. When a patient is much younger than the pharmacist

6. What kind of questions should be asked early in a patient interview?
   a. Long, complex questions
   b. Questions that can be answered "yes" or "no"
   c. Open-ended questions
   d. Leading questions
   e. Multiple questions

7. Which of the following may make an embarrassing situation worse?
   a. Being aware of potentially embarrassing situations
   b. Being sensitive to clues that the patient is embarrassed
   c. Using humor to relieve the tension
   d. Discussing the issue in a scientifically appropriate manner
   e. Communicating with the patient in privacy

8. The best way to deal with antagonistic patients is to do which of the following?
   a. Avoid them.
   b. Suggest less expensive alternative medications.
   c. Talk with their legal guardians.
   d. Speak slowly and distinctly.
   e. Limit the length of each interaction.

9. The best way to deal with physically challenged patients is to do which of the following?
   a. Treat them like any other patient.
   b. Avoid making eye contact.
   c. Stare at them.
   d. Ignore them.
   e. Physically assist them without asking permission.

10. Stress associated with platform presentations can be reduced by doing which of the following?
    a. Targeting the material for the specific audience
    b. Acknowledging the presentation as a stressful situation
    c. Anticipating and preparing for audience questions
    d. All of the above
    e. None of the above

References