EDITORIAL

Communication is Key

"The two words *information* and *communication* are often used interchangeably, but they signify quite different things. Information is giving out; communication is getting through."- Sydney Harris.

As I continue to delve deeper into the field of Patient Safety, I see recurring trends and underlying causative themes constantly surfacing. One of the biggest repetitive influential themes is communication, in particular, how the lack of communication contributes to error. Errors occur in James Reason's Swiss cheese model when the cheese is shifted allowing hazards to get through. If the lack of communication is the mode of shifting the Swiss cheese, working at improving communication is paramount to the delivery of safer care. Let me illustrate with practical examples: the labeling of prostate needle biopsy specimens, wrong site/side surgery (WSS) and return to emergency department/readmissions.

Every time a common procedure is performed, there is the potential for error to occur. A checklist or "time-out" can be of help. Prior to performing a prostate needle biopsy, a process can include the following parameters: identifying the correct patient, the proper prep and antibiotics administered, review of any cultures (urine or rectal swabs), all antiplatelet agents held, and correct labeling of specimen containers with the patient's name. And include patient expectations for any potential complications that might occur after the biopsy and discuss plans of care if they do.

Looking for causation of WSS, the literature finds failures in communication frequently as the breakdown in the system. Prevention of WSS starts with the patient in the office when surgery is discussed and agreed upon. The patient should repeat the laterality back to the surgeon, and all paperwork should be filled out in their presence at that time (i.e. the history and physical, the consent form). Having radiology films in the office and reviewing with the patient involves the patient in their own care with their upcoming procedure. Having the films then available in the OR and reviewed with the team preoperatively can reduce the possibilities of error, as well.

Returns to the emergency department and readmissions frequently result because patient expectations have not been properly managed. Or, perhaps, the patient finds consolation in going to the emergency department instead of calling or coming to the office. Communicating expected complications and, more specifically, what to do when issues arise, can reduce this risk. Maintaining accessible phone lines and other forms of contact are keys to reduce return visits.

The science of urology has progressed significantly; it is now time to match that progress in all of our avenues of communication with our patients. With increased scrutiny via patient surveys and patient communication's direct effect on errors, now, more than ever, we have to up our communication game and rally to better our patient outcomes and reduce peril.

"Speak in such a way that others love to listen to you. Listen in such a way that others love to speak to you." – Anonymous.

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