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Patricia H Strachan

Risk tells us that uncertainty exists about a specific outcome.1 Particularly when great uncertainty exists about the outcome of a procedure, the communication of risk is challenging and difficult. Medical jargon and statistics have been employed to project scientific objectivity to help manage the emotional load that often accompanies discussions in which great uncertainty exists. These approaches may create distance between physicians and patients and raise questions about informed consent. Interestingly, little attention has been focused on this physician–patient interaction, leaving best practice about the communication of high risk unknown.2 How then are we to proceed to discuss risk with our patients?

In the 1 August issue of Heart, Schaufel et al3 bravely explored the nature of patient–physician dialogues about high-risk cardiac procedures. The authors invited us to consider that communication regarding high-risk procedures is about more than the procedure and the likelihood of complications and death; it is about unspoken aspects of the human condition for both the patient and the physician. It is particularly striking that these critical conversations were of relatively short duration—6–16 minutes. This is somewhat staggering if one considers the complexity of the legal, ethical and existential aspects involved in the course of communicating risk and obtaining informed consent.

Communicating risk places great demands on both the physician and the patient. Complicated information must be translated by the physician using words or numbers that the individual before him can comprehend; the information must be imparted in a way that the physician judges the patient will understand; the facts must be understood and finally, a judgement made by the patient about whether they will accept the risk. We are reminded that whereas this process may appear to be a simple and linear one, particularly when the risk to the patient is high, the process is more complex. Patients’ resulting discomfort and uncertainty about the most appropriate decision for them in the face of high risk may result in reliance on physicians to make decisions for them. Although physicians may have been aware of this tendency, their responses suggested they were uncomfortable with assisting individual patients to explore the meaning of a decision when obtaining informed consent.

Risk communication may occur as part of a paternalistic, shared or informed decision-making process. Charles et al4 have encouraged physicians to reflect on the flow, direction, type and amount of the information exchanged when communicating risk. Whereas it would seem that the deliberation phase of decision-making would require time for patients to consider the implications, there are indications that this is a brief and undervalued aspect of patients’ decisions regarding risk.

Clearly, patients have different values and expectations that drive their preference for one style of physician–patient communication over another. What seems important is that patient and physician communication styles match, and if they do not, the onus is on the physician to accommodate his or her style to that of the patient. This requires physicians to be aware of their risk communication style, the techniques they employ and the preferences of their patients. Physicians must, therefore, develop the skills to assess patient preferences and the required knowledge and skill to adapt their communication techniques appropriately. The elicitation of patient preferences has posed a challenge for practitioners who had uncertainties about how and when to request patient involvement.5

In the case of high-risk cardiac procedures, the communication of risk may be perceived as the breaking of bad news. Viewed in this way, risk communication can be an inherently emotional undertaking for both patient and physician. Schmid Mast et al6 distinguished between three prototypes for breaking bad news that focused on the emotional stance of the physician for patients with breast cancer: disease-centred, emotion-centred and patient-centred. A patient-centred approach in which the physician was perceived to be more empathetic, emotionally available, hopeful and less dominant was preferred. The boundaries physicians set around their emotional availability when discussing risk merit reflection.

Patient-centred communication has gained wide acceptance as the preferred way to communicate with patients, yet some patients want a more authoritative “biomedical” approach.7 Those who prefer a patient-oriented approach appear to value the attention given to their emotional state, whereas those who opt for a biomedical approach appreciate a direct, no-nonsense disclosure that conveys authority, clarity and certainty.

Whichever approach is adopted, the disclosure of risk must be done in such a way that the patient is not unnecessarily alarmed.8 How is that balance to be struck? Explicit and implicit, verbal and non-verbal cues can communicate a message about risk, through narrative, numerical and audiovisual methods. Words and phrases such as “big risk” or “minimal risk” can be used to describe the threat; however, the danger in their use is that they are subject to misinterpretation and vary widely in their definition.9 Whereas physicians should frame risk in terms that patients understand, the way this is accomplished undoubtedly carries considerable influence. How is this influence transmitted? One mechanism may be to use plural possessive pronouns and adjectives when conveying risk assessment and presenting possible interventions (such as “we recommend” and “in our judgement”). Some authors have attributed such turns of phrase as devices physicians use to bolster confidence in patients about the trustworthiness and soundness of a proposed intervention.9

Analogy and story telling about a similar patient or situation are ways in which physicians can illustrate and personalise risk. Personalisation of risk must be differentiated from individualising risk. In the former, efforts are made to help patients see similarities and differences between their situation and that of another, with the goal of facilitating insight and understanding of the assessed risk. Because numerical risk estimates predict risk for a given population, extrapolation to an individual level is challenging, if not impossible.10 This presents a yet unresolved paradox for physicians; although they are able to recommend procedures to individual patients based on risk estimates for populations, patients who ask for risk estimates to be individualised may encounter further uncertainty as this fact is explained to them. This serves to complicate risk communication further.

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Despite its origins in objective science, the communication of risk remains a subjective endeavour. This challenges physicians to think about their practice in renewed ways and to reflect on difficult questions. How does the way risk is communicated make the situation more tolerable and manageable for the patient and physician?

Uncertainty about a variety of issues may give rise to physicians and patients experiencing distress. In the study by Schaufel et al., the physician offers a “deliberate plan” to reduce the distress. The plan is certain, even if the outcome is not, and this gives the patient and the physician something to hold on to, some security in the midst of the unknown future.

To paraphrase F David Peat, “risk” is a story we tell ourselves and our patients to help us manage the great uncertainties still facing us in cardiovascular care. Recognising and being honest about our limitations and accepting that we will only ever know part of the story is a good starting point to begin conversations about risk with those who seek cardiovascular care.

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