JOURNAL OF Pharmacy Practice and Research
Official Journal of the Society of Hospital Pharmacists of Australia
shpa

EDITORIAL

ETHOS, PATHOS, LOGOS: A SCRIPT FOR CLINICAL COMMUNICATION

Anyone who has spent time working with a great communicator will be left in little doubt that they have been in the presence of mastery. Readers of the *Journal* will surely be able to recall role models, authority figures and professional colleagues who have been gifted communicators, and the evidence of the self-efficacy and capability of these people will almost always be plain. Conversely, when we encounter situations where communication is not good, we also tend to remember how unsatisfying these experiences have been. Effective communication is vital in all areas of life, but none more so than when transferring intricate clinical information from one setting to another, or from one health discipline to another. This relates, in part, to the complexity and multiplicity of the information elements that need to be accurately conveyed, or because of the sophisticated terminology that may be needed, or because the stakes are so high: if the information is not transferred accurately, someone could be seriously hurt, or even worse.

There is little that is fundamental in modern life that is entirely new. A student of Plato and thought to be tutor of Alexander the Great, Aristotle was indeed a great communicator. Aristotle suggested that the three pillars of effective and persuasive communication were ethos, pathos and logos – and, indeed, when deconstructed, these three principles can be seen to be broadly applicable in good clinical communication.[1] Ethos addresses the character of the communicator: to be effective, the conveyor must be credible, empathetic to the needs of the recipient and about the subject matter, and they must communicate with good intention. Much of the behaviour of health professionals has a profound impact upon the elements central to the notion of ethos and, in a time-poor clinical environment with many competing priorities, it is easy to overlook the nuances of these elements. Conversely, pathos is traditionally regarded as more central to personal communications than in a clinical setting; many would argue that there is little place for strategies to create emotional impressions when communicating essential facts about patient care. Feelings like pity, fear, anger, frustration and respect would seem to have little relevance in conveying concise and accurate clinical information at interfaces of care, and yet the notion of pathos does have an application in modern clinical practice, in the context of teaching. Clinicians have an indisputable obligation to contribute to the development of future generations of practitioners, and those who are talented in this discipline do use pathos to strengthen the messages and technical competencies they seek to imbue in their students for the future. As such, although the concept of pathos may appear quaint to some modern clinicians, it certainly has a place in a contemporary clinical context. Finally, logos is a concept dear to the heart of the modern clinician. Dealing in the clear articulation of facts and figures, the relative merits of different approaches, statistical techniques and the holy grail of data, logos appears to stand in unchallenged primacy among the aspects of clinical communication, and pharmacists in particular are especially fond of the merits of this element of communication. Even so, without the other elements alluded to above, the logos aspect can lack persuasiveness – and when all is said and done, the key purpose for communication is to motivate and guide behaviour in the recipient. For example, in a discharge summary, the sender seeks to impart information about what happened to the subject of the communication during a hospital stay, what treatments and investigations were initiated and what the plans should be in terms of follow-up and future management, and it is in this context that the importance of issues such as quality of life and consumer-directed care become self-evident. The same could be said of a referral, such as that used by a general practitioner to initiate a medication review or other specialist input from colleagues.

The disciplines of pharmacy and medicine have long been closely connected. In fact, in times past, the patron saints of both doctors and pharmacists were Saints Cosmas and Damian, who were said to be twins who practiced as physicians around the time of Christ (the observance of the feast day for the twin saints is marked on 26 September, the day on the calendar that immediately follows the modern-day 'International Pharmacists Day'). For two professions so closely interconnected in history, a modern observer may well be inclined to ask, what has gone awry? Coverage in lay media and in some technical publications that addresses the relationship between the professions in modern times appears to be more likely to focus upon turf wars, interprofessional rivalry and bidirectional criticisms than the positive aspects of cooperation and shared responsibility for good patient outcomes. The dynamics of the interaction between the professions seem to have become strained, an

doi: 10.1002/jppr.1468

unfortunate phenomenon given how much this interaction has to offer in achieving good clinical care. In this edition of the *Journal* we see analysis of interprofessional cooperation and the attention to good clinical communication that is clearly required to work in the interests of patients. Of course, many if not most practitioners from both professions enjoy cordial, cooperative and effective communication; this something to be celebrated and built upon and, in so doing, it is acting in the interests of patients, a notion that should be central for all involved.

Conflict of interests statement

The author declares that he has no conflicts of interest.

Chris Alderman, BPharm, PhD, FSHP, CGP, BCPP
Editor-in-Chief, *Journal of Pharmacy Practice and Research*
E-mail: chris.alderman@unisa.edu.au

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COMMUNICATION TROUBLES US

Tragically, Melissa's son died.

A conference I recently attended in Canada had a profound affect on me. There were few dry eyes in the audience when Melissa Sheldrick gave an evocative account of the death of her son from a series of errors made during the dispensing process at their usual pharmacy in March 2016. Her son received baclofen (20 times the maximum dose for a child) instead of tryptophan.[1] When Melissa discovered that there was no mandatory reporting for errors made at the pharmacy, she began her advocacy work with the goal of having mandatory error reporting implemented in her home province, Ontario, and across Canada.

Melissa did not blame the pharmacist. Rather, recognising that there was no requirement for pharmacists to report errors, Melissa began to petition (via Change.org) the Health Minister to mandate that all pharmacies report their errors to a third party for data aggregation and analysis. Melissa also reached out to local provincial and national ministers of parliament. Melissa was contacted by the Ontario College of Pharmacists (the Canadian equivalent to the Pharmacy Board in Australia) to be part of a task force. Melissa recognised that the critical element for reporting errors is to adopt a 'systems approach' and not a 'person approach' when dealing with incidents. A systems approach builds preventive measures into pharmacy processes, so that the same error does not occur again. Melissa has been quite clear that for mandatory error reporting to work, there is a need for collaboration and communication – that is, avoiding a culture of shaming and blaming. Change has happened quickly, with other provinces following the Ontario decision to mandate the reporting of medication incidents. Melissa has been told that she achieved more in 20 months since Nova Scotia began their error reporting program than was achieved in the prior 10 years. Melissa vows to continue her advocacy until all provinces in Canada mandate anonymous reporting.

Tragically, Kristy and Amanda's dad also died.

On my return to Australia, I was saddened to read the coroner's report on yet another patient death due to a medication.[2] Let us briefly look at this recent example, which occurred in Victoria. Ian Gilbert died when dispensed methotrexate in a dose not consistent with its intended purpose. The pharmacist contacted the prescriber about the inappropriate dose, but was informed that the dose prescribed was correct; the prescriber was described by the pharmacist in the coroner's findings as 'firm, confident and resolute'.[2] However, the pharmacist was not reassured by the prescriber about the (inappropriate) methotrexate dose; the pharmacist even changed the instructions on the medication label (and then changed it back). The pharmacist completed a clinical intervention form to record her interaction with the prescriber.

We can speculate there are several reasons why the pharmacist felt compelled to dispense an unsafe dose of a drug. Why did the pharmacist dispense this lethal dose of methotrexate? When asked this specific question, the pharmacist said, '*[It's] a good question. I don't know. I mean I don't know. Yeah I really don't know.*'

The coroner made several comments, including the following:

> *Doctors and pharmacists should trust and respect each other, whilst retaining their independence. In dismissing her concerns, it appears that [the GP] did not afford [the pharmacist] the respect she deserved. In dispensing the methotrexate despite her concerns, it appears that [the pharmacist] afforded [the GP] too much respect, or at least lost sight of her role as an independent safeguard against inappropriate prescribing.*[2]

Did the pharmacist in this case feel disempowered? One of the expert witness general practitioners (GPs)