Original Scientific Paper

Communication in practice:

Auckland general practitioners reflect on communication events and identify their training needs

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ABSTRACT

Objective

To describe practising New Zealand (NZ) general practitioners' (GPs') experiences of satisfying and dissatisfying communication experiences with patients, and identify their perceived needs for continuing education in communication skills.

Methods

Telephone interview survey of randomly selected Auckland GPs. Data analysed using SPSS-12 and by thematic content analysis.

Results

Eighty GPs interviewed. GPs described positive experiences of 'good quality' relationships, ability to assess the patient's agenda and acknowledgement of cultural issues. Negative experiences focussed on 'difficult' patients, doctors' emotional reaction, impaired communication (culture or disease) and language barriers. There were issues around process (for example, lack of time) and specific content (such as dealing with terminal illness). GPs were clear about wanting training in manageable chunks, skilled facilitation, interaction and convenient access.

Recommendations

Communication training should use a patient-centred approach, whilst addressing specific issues where GPs felt uncomfortable or unskilled, such as consultations with high emotional content and difficulties around language comprehension. Communication training needs to be focused, accessible, interactive and appropriate to local settings. Outcomes need to be achievable and lead to actual change.

Key words

Family physician, communication; communication barriers

(NZFP 2006; 33:30–38)

Introduction

Communication skills are accepted as core health professional skills and are taught in undergraduate and continuing medical education. Although individuals have different degrees of innate skill, communication techniques and behaviours can be learnt.[1] There is good understanding of some of the processes within consultations through a variety of models,[2,3] from Balint in the 1950s through to the revised Calgary-Cambridge model of this century.[4] Communication problems continue to feature strongly in complaints and litigation[5] and the need for regular review and updating of skills is acknowledged.

There is a substantial history of in-service and postgraduate training in communication skills for general

practitioners (GPs) internationally.[6-9] There is also a strong history of training locally. To meet the growing need for such training on a more systematic and focused basis, the following must be considered:

- Perceived changes in patients' requirements, especially recognising the increasing cultural diversity of patients, and the increasing sophistication of services required of the GP.
- The nature of complaints by patients about inadequate or inappropriate communication.
- The increasing numbers of overseas-trained medical practitioners in both urban and rural practice, offering challenges and opportunities to develop effective and culturally appropriate communication skills with patients.
- The development of systematic programmes in communication training in other countries, notably Australia and the United Kingdom,[10,11] and the challenge that this provides for New Zealand medical educators.
- The development of early communication training programmes at the undergraduate level and the need to recognise this in postgraduate training as well as the disparity that this might create between established and newly trained GPs.

Taken together, these reasons provide a compelling case for ascertaining the communication skills needs of GPs in terms of level, focus and quality, and to use this information to develop a focused and systematic continuing education training programme.

The Auckland region houses a third of NZ's population and is diverse with respect to ethnicity (including refugee populations), socioeconomic status and organisation and access to primary health care.

The aim of the study was to conduct a needs analysis of the scope and nature of communication training requirements as perceived by GPs in the greater Auckland region by identifying:

1. The communication experiences of GPs in their daily practice through reflection on positive and negative aspects.
2. The communication issues with which GPs felt they needed help and the most appropriate way to deliver that help.

This personal collection of issues and suggestions could then be compared with the content and approach of typical communication training, to help develop and evolve appropriate and responsive training and support.

Methods

The sample were 80 randomly selected GPs in the greater Auckland area using a computer-generated random number list from an up-to-date GP database. Doctors not currently practising as a GP in the Auckland area or no longer able to be contacted at the listed address were deemed ineligible.

Interviews with key informants who represented organisations or specific groups of GPs helped inform the development of the survey questions. Stakeholder informants included Maori, Pacific Island and Asian people, the Medical Council of NZ, Medical Protection Society, practice nurses, the Institute of Rural Health, the Practitioner Development Unit, the RNZCGP, local GP groups and the Goodfellow Unit. Interviews took between 25 and 60 minutes. If stakeholders consented, interviews were taped. Findings were summarised and checked with the interviewees for accuracy and omissions.

The questionnaire was designed for delivery by telephone interview with simultaneous data entry into a computer-based spreadsheet. It was initially piloted with several GPs. See the Appendix for the interview pro forma. Data collected included demographics, communication skills training experience, personal communication issues relating to practice and specific areas of communication difficulty. Initial contact was made by faxed or posted letter, including the participant information sheet. The research assistant conducted a telephone follow-up inviting the GP to participate in a telephone interview of approximately 20 minutes duration, conducted at a time of their choosing. An honorarium was offered to GPs as a contribution towards their time.

All interviews were audio taped with the GPs' consent, providing a means of auditing the electronically-entered data. The interviewer followed the standard set of questions in the questionnaire plus optional prompts.

Quantitative data was entered into SPSS-12 statistical package. Descriptive statistics were produced and comparisons made using non-parametric tests of significance. Open qualitative data were analysed using a general inductive approach. One of the researchers was experienced in qualitative analysis and led this process. Using thematic content analysis, individual text responses were coded according to emergent themes. The data then were collated to produce a series of major and sub-themes through ongoing discussions and re-reading of the data until consensus was reached among the researchers. To provide rigor, the data were independently coded by four researchers as a consistency check with discrepancies resolved by adjudication. Themes were determined and combined through discussions among the researchers until consensus was reached.

Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee.

Results

Data saturation was reached at 80 participant GPs. From 178 GPs randomly selected and contacted, 25 were ineligible (excluded because of location, no longer in general practice, wrong contact details) and 73 declined to participate. This gave a response rate of 52.3% of eligible GPs.

The 80 respondents represent a rough parity between genders, with a slight preponderance of males (53%). While about half were NZ-born (58%) and of European ethnic-

ity (48%), the others were born in a wide range of countries representing a broad spectrum of cultures. About half of respondents (49%) were in their forties, with a decreasing spread on either side of this age group. Two-thirds (68%) received their basic medical training in NZ with three-quarters graduating after 1980 (76%). The vast majority (83%) were either Members (31) or Fellows (35) of the RNZCGP. Three-quarters (75%) had at least one postgraduate qualification (mostly diplomas). The majority had attended some communication skills training associated with their postgraduate general practice vocational training. Twenty per cent had undergone further specific training such as cognitive behavioural therapy, motivational interviewing or counselling and three (4%) had completed formal postgraduate papers in communication.

Communication successes

High quality relationship

In response to a question seeking reflection on an especially pleasing communication event, the strongest theme to emerge involved establishing a high quality of relationship with the patient, both in terms of rapport/trust/reassurance and in active listening/empathy:

GP5: *'A new patient who had clinical signs of depression but I got rapport and talked through it as well as getting all past history medical details, and we made plan of action. She seemed happy too.'*;

GP23: *'Since done the PRIMEX course, have read one of the books which teaches you how to be patient-centred. When uncertain, put the ball into the patient's court, and allow them to do the talking and express what their fears are or what they are particularly worried about.'*

Hidden agenda

The second most prominent theme of satisfaction involved respondents' ability to uncover hidden issues:

GP42: *'I saw a lady who came in with a facial rash and I thought she looked a bit anxious/worried and so when I asked her what else was going on in her life, I found her husband is going bankrupt.'*

GP32: *'A young lady who came in with abdominal pain and really the underlying issue was, was she pregnant? and trying to organise contraception.'*

Relating to patients with different ethnic or other specific characteristics

Another important theme to emerge involved respondents' ability to relate to patients with certain characteristics, including those from a different cultural (mostly ethnic) background, and those with mental health problems:

GP31: *'I speak Tongan and that is a big plus, because I can communicate clearly with some of the older Tongan patients who don't speak English well. It is nice when they come and say that they have been to another doctor who doesn't understand what they are saying and its nice to come and see someone who speaks same language.'*

There was a strong feeling that patients received a poorer service where language was a barrier to communication. Issues with humour, interpreting mood, subtleties of thought and emotion were all seen as hostage to language problems

GP30: *'One of my patients is depressed, and when he has emotional ups and downs he comes running to me and talks to me and then feels better and is happy. I have very good rapport with him.'*

Communication problems

Participants were also asked about an occasion when they were particularly unhappy with their communication performance and to identify general problem areas.

Language

By far the most common type of communication difficulty for the GPs was where language is a barrier (91%). However, more than half of the doctors (52.5%) spoke at least one additional language to English. Thirty-one different languages were mentioned, the majority being used often or occasionally in patient consultations (83%).

Most experienced problems on a weekly basis (42.5%) and some dealt with language problems daily (15%). Seventeen of the doctors were seeing these issues, at most, monthly; the remaining participants did not comment on frequency. Of the seven doctors who felt that they didn't have a problem, five still identified that they were dealing with patients for whom English was a second language.

Two distinct groups were identified when analysing the patients with whom GPs struggle – language problems per se:

GP 4: *'It's never easy to communicate with someone for whom English is not a first language.'*

GP18: *'There was this situation with a Chinese woman who couldn't speak English. She came with a translator and I sort of missed the point initially, in the first consultation, but I did better in the second.'*

..and perception of speech:

GP35: *'friend who acts as translator...feel like not getting the real story.'*

Most prominently, Asian patients, whose first language was not English, were the group with whom GPs were likely to struggle, closely followed by Maori and Pacific Island patients.

Migrants often had a variant of English that could make consulting confused and simplistic. GPs sometimes resorted to drawing pictures, or used dictionaries and word lists. There was a strong feeling that patients received a poorer service where language was a barrier to communication. Issues with humour, in-

terpreting mood, subtleties of thought and emotion were all seen as hostage to language problems.

While the benefits of an interpreter to translate were acknowledged, the pitfalls and problems were mentioned frequently. Particular issues raised were about who interprets (including gender, age and relationship), quality, confidentiality, effect of the problem being discussed and the amount of time needed (both setting it up and during the consultation).

In addition to language problems, the effects of cultural norms, behaviours and attitudes were seen as an additional potential stumbling block: dress, customs, religion, non-verbal communication, power and touch were all mentioned.

Different cultural background

Less frequently GPs cited trouble communicating with patients whom they regarded as coming from a different cultural background other than ethnicity, for example adolescents:

GP17: *'I suppose your teenage boys who don't talk to anyone, monosyllabic; I'm probably no worse than a lot of people but it doesn't feel exactly like you've communicated thoroughly.'*

'Difficult patients'

Respondents were often most dissatisfied when patients were seen as either uncomfortably emotional or 'difficult':

GP11: '*...aggressive, angry or manipulative patients...*';

GP33: *'People who come in with definite fixed agenda that they have a particular want or are drug-seekers.'*

GP60: *'Generally ones that come having self-diagnosed and only wanting you to believe what they've diagnosed; often very well educated and read, may have gone to Internet site and got misinformation so very difficult to turn around, to try to suggest other things or tell them otherwise can be very difficult.'*

There was often a mis-match of expectations as well:

GP21: *'Patient came seeking benefit who I didn't think was eligible.'*

This issue of the 'difficult patient' tended to break down into a number of causes, sometimes compounded.

GP14: *'When there is cultural or different expectations of how I should manage certain problems.'*

GP 72: *'I'm just getting nowhere at present, patient is married to his illness – emotional vested interest in remaining ill.'*

GP 35: *'Every so often have consultation with a patient where its not that clear as to what the nature of the presenting complaint is. Usually there's a multitude of complaints but it's hard to know which is the one of most concern or greatest medical importance; on occasions the consultation will finish but I have a feeling that I haven't got to the crux of the problem, or may have addressed a number of other issues or problems but the main problem may not have been addressed.'*

Non-compliance

GPs were also dissatisfied when patients did not comply with their recommendations:

GP45: *'The worst one is when a parent is going to not look after their child in the best way and you're trying to convince them that their actions are not in the child's best interests; but they've made their mind up and when you try to reason with them you have no impact.'*

Imparting bad news

In the case of imparting bad news, the difficulty and emotional turmoil was often on the doctor's part:

GP74: *'Sometimes terminal cases, cancer patients; these can be very difficult. Cases where family don't want the patient to know, where they think the patient will die early. It takes time to discuss with family their options and what the decisions are that need to be made.'*

Patients with specific communication impediments

Problems were also identified when interacting with patients who had a hearing problem, learning difficulties or neurological or mental health conditions that affected speech.

GP3: *'Worst was one of my dearest patients, mid-90s, absolutely deaf from a young girl and going blind as well, deteriorating mentally, getting more and more frightened and worried with her physical state, she couldn't hear anything and her visual performance which we really needed was getting less and less. We went through times of frustration, worry, depression with her yelling – it kept recurring. Most frustrating trying to get through to a lady who couldn't communicate well, and had a bit of dementia as well.'*

GP2: *'I laughed at a pun made unintentionally by a patient with a low IQ who could not understand my explanation of why I laughed. He felt laughed at and I felt bad because I had not realised the extent of his intellectual difficulties.'*

Process problems

Mis-communication or when the communication process is inadequate, also came through as a theme on its own:

GP22: *'Very difficult people who I look after, who are not prepared to listen, who make their own judgements and decisions and are really locked off to anything that I say. It's their choice, still endeavour to communicate but is a very frequent part of my job.'*

Time pressure

Another important theme was time pressure which threatened the structure of the consultation:

GP45: *'The most frustrating thing and biggest barrier to communication is when I don't have time to work through the process.'*

Content issues

Some GPs expressed difficulty in explaining benefit and risk:

GP63: '*Sometimes I find it hard to explain risks or benefits of screening or treatment – it is just having the figures at your fingertips – our patients ask for them a lot.'*

..dealing with sensitive topics:

GP16: *'I have trouble with the sexual side of things...I don't volunteer on that too much unless it seems to be obviously coming up.'*

..and confronting treatment compliance problems:

GP22: *'With diabetes and smoking it is hard getting the message across to people about the long term consequences...and motivating them without my using a big stick threatening approach which never works.'*

Clear and appropriate delivery and receipt of information was identified as a complex problem with comprehension of concepts being an important feature. Doctors found it hard to be sure that they both understood patients' needs and were able to convey their knowledge and a shared plan of action.

Expressed needs and format for training

A wide range of issues was noted to be desirable in a proposed communications skill training course. The strongest theme to emerge was dealing with emotional issues in the form of difficult patients, in particular ones who were angry:

GP43: *'Would definitely like more skills in how to deal with unhappy, angry, arrogant, aggressive patients, with outcome being good, which I think I'm not very good at.'*

Another issue to emerge strongly was imparting bad news:

GP8: *'Some people can take the news that they are going to die really well whereas some people take the news that they have anaemia really badly.'*

Several other topics were mentioned somewhat less frequently.

One involved the quality of relationship issues in the form of active listening/empathy and establishing rapport:

GP56: *'The power of listening is the most important thing on my list.'*

Another theme concerned aspects of the consultation process in the form of language difficulties and mismatching expectations.

GP16: *'Language issues – common words in other languages, education on pronunciation of foreign names – embarrassing when can't pronounce someone's name in the waiting room properly.'*

GP 39: *'How to handle different people, some patients are aggressive and they think that they will get what they want, and putting one's firm foot down with them works well, and telling them to find someone else for that.'*

A further cluster focuses on dealing with particular client characteristics, like cultural difference, especially ethnicity, but also teenage; and mental disorders like depression:

GP25: *'Courses aimed at extending understanding of immigrants especially Asian but also other religions and how they affect their culture and therefore their medical care. ...more needs towards recent immigrant populations who have a lot to offer but whose skills are often downgraded in NZ.'*

GP11: *'Dealing with psychiatric illness, emotional, general psychiatry. Managing the difficult patient, like the angry, depressed, violent, emotionally disturbed type of patients.'*

The only structural issue of note concerns managing time pressures:

GP38: *'How to get more out of a patient quicker – I run too late. I think it's developing good practice really, so pointing out things that I do that aren't so effective, and giving some suggestions.'*

The most meaningful experience of doctors undertaking a training programme were non-technical, humanistic interactions with patients

The GPs in this study preferred communication skills training through one-off, face-to-face, facilitated small groups using actors for role play (peer role play was a less favoured option). They did not want a workbook-only or distance learning course even if the material was in a current multimedia format. Women preferred interactive methods and one-off courses and rejected distance learning more strongly than men. GPs wanted to attend training courses at places that were easy to get to (venues near their practice or home). Midweek evenings were convenient for nearly all (94%) with the most convenient starting times being 7:00 or 7:30 pm. One-third (33%) also said that weekends (usually Saturdays) were convenient.

A number of practical barriers to attending training courses were identified, but comments by most GPs indicated that these could be overcome if the GP was sufficiently motivated or interested in attending a particular course. Fourteen per cent identified no barriers to attending a course. Practical barriers required GPs to be selective about which training courses they attended. The most commonly stated practical barriers were time (55%); child care and family life (28%), and cost (21%). Four per cent commented that they needed advance warning to plan ahead for particular training courses.

Discussion

The survey results indicate that respondents get greatest satisfaction when they are able to establish what they perceived as a high quality relationship with their patients, as evident in the depth of rapport or trust established, and in the quality of listening and empathy skills used. This is consistent with international findings that the most meaningful experience of doctors undertaking a training programme were the non-technical, humanistic interactions with patients.[12] Their international colleagues also place a high priority on the quality of the physician-patient relationship.[13] They echo their international counterparts in the situations, kinds of patient and types of information they identify which challenge their ability to communicate effectively and whom they perceive are the 'difficult patients'.[6,14–16]

A strength of this study was the combined use of literature review plus qualitative and quantitative data. The review highlighted the major themes and issues in communication training and was incorporated with stakeholder feedback to inform the design of the questionnaire subsequently used in the telephone survey. Use of a random sample also increased the potential generalisability of the findings, especially for urban and suburban GPs. The sample involved the greater Auckland region but would not necessarily represent the isolated rural GP.

The survey sample is likely to be representative of NZ GPs as a whole. The demographic details of members of the RNZCGP are available for 1996[17] and 2000[18]. The 1996 data is based on an 82% response rate from surveyed GPs but does allow for some comparison of the GP workforce over time. In 1996, 55% of NZ GPs were 40 years or older and in 2000 this had risen to 70%. In our sample in 2004, 76% were in this age bracket, which is consistent with the reported ageing membership. Similarly, the proportion of male GPs has declined steadily over time. The GP workforce was 64% male in 2000. Our sample was 53% male, which is in line with the increasing feminisation of the profession.

In 2000, 65% (1436/2221) of the GPs with recorded place of graduation had trained in NZ, 70% (1006/1436) of these in Otago. Our sample matched this closely, with 68% (54/80) training in NZ (65%; 35/54 in Otago). In 2000, 50.5% of College membership were Fellows (fully vocationally registered); 14% were Members (completed an approved training programme and passed the PRIMEX examination) and 25% were Associate Members (not yet completed a training programme). In our sample 86% were either Fellows or Members. College membership has moved from a voluntary status to a Medical Council requirement unless a doctor chooses to practise under oversight. The past four years has seen a big increase in GPs sitting and passing PRIMEX, and hence a decline in Associate Membership.

The majority of GPs indicated that they had undertaken some form of postgraduate communication training, with 20% partaking in training related to specific issues, such as counselling and cognitive therapy. The need for training in cognitive therapy, behavioural therapy, and counselling has previously been identified.[6,14]

An effective training programme needs to be significantly comprehensive to allow actual behaviour change in GPs' professional practice

Both our field study and the literature review can help inform new course development. Addressing specific issues for a communication training programme is a multi-faceted task. Language difficulties require consideration of such issues as comprehension, culturally-appropriate accessing deeper issues, and the use of translators.[19] Additional topics useful for inclusion in training programmes include dealing with emotional patient issues, particularly angry patients, giving bad news, and time management issues related to the consultation.[6,8] Within a patient-centred paradigm, such a task involves trust-building, empathic listening, aligning expectations, discussing sensitive issues, managing patient feelings, and negotiating mutually-acceptable treatment outcomes – all in a culturally sensitive manner and within a strictly limited time frame. It is the complexity of these interrelated issues which constitutes a necessary component of any training programme. An effective training programme needs to be significantly comprehensive to allow actual behaviour change in GPs' professional practice.[9]

The need for clear goals and achievable outcomes have clear implications for how training should be structured. Auckland GPs have a clear preference for one-off, face-to-face, facilitated small groups, with a practical focus, and use of actors or peers for role plays. Women in particular favour one-off interactive workshops. While there was a desire to have role play involving actors, GPs in our study were not keen on the use of peers as simulated patients. This specific caveat was not mentioned in the literature reviewed, but is probably related to an anxiety about making the experience realistic and 'performing' in front of peers. Mid-week evening courses, held near GPs' practices, were favoured by many in order to cut down on travel time and loss of family time.

Some of these findings are very much in line with overseas experience,[1,14] whilst others are novel or reflect a different perspective. There are strong consistent indicators for a particular training format.

However, it is also necessary to take into account the cautions sounded in the research literature,[7,9] and have a comprehensive and integrated approach to any training topic with emphasis on direct application to GP professional practice and clear relevance to the individual practitioner. There is a body of literature indicating that ingrained GP behaviour requires a number of educational interventions over time and 'one-off' short courses may be ineffective.[20,21]

A limitation of this study was the 52% response rate. It is possible that non-responders were less skilled or interested in communication. However, much of the data collected was qualitative and data saturation was certainly achieved with interviews of 80 randomly selected GPs. A further limitation is that the study relied on GPs' self-reported successful and unsuccessful communications and GPs may not be able to identify their own weaknesses. The patient's voice was not sought in this study but could add a further dimension to what constitutes effective communication.

In summary, Auckland GPs prefer communication skills training to be addressed within one-off, small and focused workshops, acknowledging that multiple interventions in a variety of formats are most likely to result in clinical behaviour change. Midweek workshops, held near the GP's own practice, are much preferred because they are least disruptive to family time and involve less travel time. All communication and its associated training must take into account issues of cultural appropriateness and the strictly limited time frame available in GP consultation.

Role playing with video feedback is not always enjoyable, but it is respected as a very effective way of practising desired behaviour – especially when actors are directly involved.

Within a patient-centred paradigm, the management of any one communication issue involves a set of interrelated skills, including trust building, empathic listening, aligning expectations, discussing sensitive issues, managing patient feelings, and negotiating mutually-acceptable treatment outcomes. Training in communication thus requires attention to a range of interrelated skills within the one workshop.

While some teaching input is acceptable, primary emphasis needs to be placed on the facilitation of participant-determined agendas. Appreciation of what patients consider of value is also important. The desired outcome from communication training is behaviour change in the GPs' clinical practice, which goes well beyond giving information and helping participants feel good.

Acknowledgement

This study was funded by the Campbell MacLaurin and Phil Barham Fund for the Support of Research and Development in Continuing Medical Education in General Practice and by the Charitable Trust of the Auckland Faculty of the Royal New Zealand College of General Practitioners. Thanks to the stakeholder and GP respondents for their participation.

We would like to express our appreciation to the general practitioners in this study who generously gave of their time.

Competing interests

None declared.

Appendix: INTERVIEW PRO FORMA

Thanks for agreeing to participate in our study. I would like to tape this interview if you agree. Is that OK with you?
...I'm switching on the tape now. First I'd like to ask you some details about yourself.

Gender:	Male	Female				
Country of birth:	.....					
What age group are you in? 20s, 30s, or what?		20–29	30–39	40–49	50–59	60+
Ethnicity:	NZ European	Other:.				
Medical school:	Univ of Otago	Univ of Auck		Other:		
Year of grad:	19					
Postgrad Qualifications:	RCNZCGP:	Fellow		Member		Assoc member
Dip Obst	PhD	Masters in GP/HS or other:		.....	Other:	

1. Have you had any specific training in communication skills since medical school?
   If yes, what? {*prompt: when*}

Now thinking about communication in your practice:

2. Can you recall an occasion from your practice where you were especially pleased with your communication performance?
   If yes: Can you tell me a little about it? {*If not clear: Why did you think that was particularly good?*}

3. Can you recall an occasion from your practice where you were particularly dissatisfied with your communication performance?
   If yes: Can you tell me a little about it? {*If not clear: Why were you particularly dissatisfied?*}

4. What kind of patients do you find it hard to communicate with?

5. In what kind of situations with patients do you find it most difficult to communicate?

6a. Is there information you find difficult to communicate to patients?

6b. Do you find it hard to explain benefits and risks of screening or treatment? And would more skills around explaining benefits and risks of screening or treatment be useful to you?

7. Do you speak any language other than English?
{If yes: What languages and do you consult in these? If yes: How many times per week?}

8. Do you ever struggle with communication due to language difficulties?
If yes: What sort of issues and how often?
{prompt: English not GP's 1st language; many non-English-speaking patients; interpreter issues}
{if not already discussed: How often?}

9. Do you have any difficulties in your communication with your primary health care team or other health care professionals?
If yes: Can you tell me about these {reassure anonymity}?

10. Do you communicate with patients by email? Yes No
What do you see are the usefulness and problems with this?

Now thinking about communication skills training:

11. What particular topics /issues would be of most use to you in such a course?

12. Now I've got a list of different types of training methods.
Please could you rate these 1 to 5, where 1 is 'no use' and 5 is 'very useful' to you.

Face-to-face courses (i.e. attending a meeting)

Lectures

Small group meeting without facilitator but with provided resources

Facilitated group discussion (a facilitator leads a discussion involving, for example, case studies)

Use of actors for role-play

Use of peers for role-play

Videotape and feedback

One-off workshop

Modular course over several months

Distance learning

Written material only (workbooks)

Video and workbook package

CD-ROM / DVD

Web-based interactive learning

13. If you prefer face-to-face, what locations would suit you best?

14. What times and days would be most convenient for you?

15. Is there anything else that is important to you in communication skills training?

16. Are there any practical barriers to your attending a course?

17. Any other comments?

Many thanks for giving up your time for this interview – your responses have been very helpful.

References

1. Aspegren K. Teaching and learning communication skills in medicine: a review with quality grading of articles. Medical Teacher 1999; 21:563–570.
2. Kurtz SM, Silverman JD, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. Academic Medicine 2003; 78:802–809.
3. Draper J, Silverman J, Hibble A, Berrington RM, Kurtz SM. The East Anglia Deanery Communication Skills Teaching Project – six years on. Medical Teacher 2002; 24:294-298.
4. Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge Guides. Academic Medicine 2003; 78:802-809.
5. Lussier MT, Richard C. Doctor-patient communication: complaints and legal actions. Can Fam Physician 2005; 51:37-39.
6. Girgis A, Sanson-Fisher RW, Walsh RA. Preventive and other interactional skills of general practitioners, surgeons, and physicians: perceived competence and endorsement of postgraduate training. Preventive Medicine 2001; 32:73-81.
7. Hulsman RL, Ros WJG, Winnubst JAM, Bensing JM. Teaching clinically experienced physicians communication skills. A review of evaluation studies. Medical Education 1999; 33:655-668.
8. Levinson W, Roter D. The effects of two continuing medical education programs on communication skills of practicing primary care physicians. Journal of General Internal Medicine 1993; 8:318-324.
9. Cegala DJ, Lenzmeier Broz S. Physician communication skills training: a review of theoretical backgrounds, objectives and skills. Medical Education 2002; 36:1004-1016.
10. Australian General Practice Training. Communication skills and the patient-doctor relationship. Canberra: Australian Royal College of General Practitioners; 2004.
11. Royal College of General Practitioners. Portfolio of evidence of professional standards for the revalidation of general practitioners. London; 2004.
12. Horowitz CR, Suchman AL, Branch WT, Jr., Frankel RM. What do doctors find meaningful about their work? Annals of Internal Medicine 2003; 138:772-775.
13. Lewin SA, Skea ZC, Entwistle V, Zwarenstein M, Dick J. Interventions for providers to promote a patient-centred approach in clinical consultations. In. Oxford: The Cochrane Library; 2003.
14. Kerwick S, Jones R, Mann A, Goldberg D. Mental health care training priorities in general practice. British Journal of General Practice 1997; 47:225-227.
15. Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Pract 2002; 15:25-38.
16. Roter DL, Hall JA. Physician gender and patient-centered communication: a critical review of empirical research. Annu Rev Public Health 2004; 25:497-519.
17. Kljakovic M. A profile of New Zealand General Practice. Wellington: Royal New Zealand College of General Practitioners; 1998.
18. Wilkinson M, Flegg K. Who are the GPs of New Zealand? NZFP 2001; 28:260-263.
19. Prasad V, Darrad K. 'A touch of spice' – General practitioner registrars' views about cross-cultural communication. Education for Health 2003; 16:222-227.
20. Kramer AW, Dusman H, Tan LH, Jansen JJ, Grol RP, van der Vleuten CP. Acquisition of communication skills in postgraduate training for general practice. Medical Education 2004; 38:158-167.
21. Brown JB, Boles M, Mullooly JP, Levinson W. Effect of clinician communication skills training on patient satisfaction. A randomized, controlled trial. Annals of Internal Medicine 1999; 131:822-829.

Primary care research in New Zealand: Ahead of the rest of the world!

Research provides us with the evidence that enables us to be more confident that we are helping our patients to make appropriate choices for their health care.

Research in primary medical care has expanded dramatically in the past 30 years with fewer than 300 papers being published in 1975 to more than 4000 being published in 2003. By far the largest contributors to this growth are the USA and the UK. In New Zealand there is a feeling that we have been struggling to keep up with the rest of the world. However, a recent paper[1] reassures us that not only are we keeping up but, if we relate the number of published papers to the population of the country, we share the lead with the UK and Australia. If the number of primary care publications is set in relation to the total number of publications in human medicine we top the table with 4.6%, ahead of Australia (3.8%), the UK (3.6%), Norway (2.8%), and South Africa (2.6%).

As this study was performed using the Pub Med database, papers published in the NZFP would not have been included. We hope to change that in the near future.

Congratulations to our primary care researchers. You are contributing nationally and internationally to the growth of our discipline.

Editor, NZFP

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[1] Ovhed I, Van Royen P, Håkansson A. What is the future of primary care research? Scand J Prim Health Care 2005; 23:248-253.