Good communication skills:
Benefits for doctors and patients

Susan J Hawken MBChB MHSc(Hons) FRNZCGP Dip Obs

***Susan Hawken** is a Senior Lecturer in the Department of Psychological Medicine, Faculty of Medical and Health Sciences at the University of Auckland. She works clinically in the area of reproductive and sexual health medicine. Her research interests include the teaching and learning of communication and professional skills cross-culturally.*

Introduction

Good communication skills are essential for high quality, effective and safe medical practice. These skills are used for information gathering, diagnosis, treatment and patient education. Recent research shows that when the doctor uses effective communication skills, both doctor and patient benefit. As a result, medical schools and specialist colleges are emphasising their importance. Communication skills are now listed as core competencies in training programmes, including NZ's GPEP.[1]

Problems no longer lie in demonstrating the effectiveness of therapeutic communication skills; rather today's problems are concerned mainly with how to transfer such skills from training programmes into daily practice. This paper summarises some of the more important findings in the area. First I describe core communication skills and factors which influence their use, especially the nature of the diagnosis and gender of the practitioner. Next I locate the communication skills in the context of the consultation. Finally I report recent findings on whether or not communication skills can be learned and implemented.

What are core communication skills?

There have been many reports on what constitutes core communication skills, including the Toronto Consensus,[2] and the Kalamazoo Consensus.[3] These reports and other texts[4] all document similar skill sets. See Table 1 for essential communication skills from the Kalamazoo Consensus.[3]

Why is eliciting the full set of patients' concerns at the start of the consultation critical? A frequently cited study[5] from the 1980s reported that doctors interrupted their patients after a mean time of 18 seconds and that only in one of 52 visits did the patient return to complete voicing all their concerns. This study was replicated in 1999[6] in the USA/Canada to see if the behaviour of doctors had changed, and whether there was difference in behaviour with experienced GPs. In 264 visits, the GPs solicited the patients' concerns in 199 (75.4%). Patients' initial statements of concern were completed in 28% of visits. GPs interrupted/redirected the patients' opening statement in a mean time of 23.1 seconds, (vs 18 seconds in the earlier study). Patients allowed to complete their statement of concern took only six seconds longer on average that those who were redirected. Late arising concerns were more common when doctors did not solicit patient concerns during the interview (34.9% vs 14.9%). The GPs with fellowship training were more likely to solicit all the patients' concerns and allow patients to complete their initial statements (44% vs 22%). These authors concluded that soliciting the patient's agenda takes little time, can improve interview efficiency and yield increased data.

In gathering information, what communication techniques have been shown to be useful in general practice? A systematic review[7] has been undertaken of studies of GP–patient interactions. To meet the criteria for inclusion, studies had to measure specific behaviours reliably and also to provide empirical evidence of their influence on patient outcomes. The authors found 14 studies of verbal and eight studies of non-verbal communication which met their criteria. Refer to Table 2 for a summary of the behaviours linked to positive patient outcomes.[7]

Behaviours to be avoided include being unduly dominant, angry, nervous or directive. It is interesting to note that these authors[7] found that the physical examination has not been studied with respect to nonverbal behaviours and touch.

Are there gender differences in doctor–patient communication? There is equivocal evidence on this point. A review of gender differences[8] found that female physicians had, on average, two-minute longer consultations. In this time they engaged in more active partnership behaviours, positive talk, psychosocial counselling, psychosocial question-asking and emotionally-focussed talk. How-

ever other studies have shown no difference,[9,10] but in the large Second Dutch National Study[10] women GPs were more patient-centred.

A more important determinant of consultation length may be the diagnosis, as it has been shown that consultations on psychosocial problems take longer and that the doctor's perception of psychosocial problems is more predictive than the patients.[9] In a general practice study[11] across Europe it was found that, in consultations about psychosocial problems, GPs showed more affective behaviour, were more concerned about having a good relationship with the patient, asked more questions and gave less information. Longer consultation times for psychosocial problems have implications for daily scheduling of appointments and how GPs deal with time pressures. The review of gender differences[8] reported that studies have shown that male doctors respond to time pressures by dispensing with socio-emotional and psychosocial topics, while women do not. There is currently no good evidence on whether these gender differences impact on patient care, satisfaction or outcomes.

The patient-centred approach

Communication skills cannot be considered in isolation but as an integral part of the process of the consultation. In general practice the well accepted patient-centred method[12] incorporates six interactive components; refer Table 3.

1. Benefits for patients when the doctor utilises the patient-centred approach and effective communication skills

Patient satisfaction and compliance

Patient satisfaction has been clearly linked to a patient-centred approach; for a review see Silverman J, Kurtz S, Draper J. *Skills for communicating with patients*.[4] In a study of sore throats in general practice, satisfaction with the consultation predicted the duration of illness and was strongly related to how well the doctor dealt with the patient's concerns.[13] Doctors' information-giving is also related to patient satisfaction.[14] Physician nonverbal behaviours showing immediacy (distance between the patient and doctor, forward lean, body orientation) are associated with higher levels of patient satisfaction.[15] More recently, a large UK general practice study[16] reported that if patients do not receive a patient-centred consultation they are less satisfied, less enabled, may suffer greater symptom burden and higher rates of referral. An-

Table 1. Essential communication skills: Kalamazoo Consensus[3]

Open the discussion
• Allow the patient to complete his/her opening statement • Elicit the patient's full set of concerns • Establish/maintain a personal connection
Gather information
• Use open-ended and close-ended questions appropriately • Structure, clarify and summarise information • Actively listen using nonverbal and verbal techniques
Understand the patient's perspective
• Explore contextual factors (e.g. family, culture, spirituality) • Explore beliefs, concerns, expectations about health and illness • Acknowledge and respond to the patient's ideas, feeling and values
Share information
• Use language the patient can understand • Check for understanding • Encourage questions
Reach agreement on problems and plans
• Encourage the patient to participate in decisions to the extent that he/she desires • Check the patient's willingness and ability to follow the plan • Identify and enlist resources and supports
Provide closure
• Ask whether the patient has other issues or concerns • Summarise and affirm agreement with the plan of action • Discuss follow-up

Table 2. GP behaviours linked to positive patient outcomes[7]

Verbal behaviours	Nonverbal behaviours
Empathy	Head nodding
Reassurance and support	Forward lean
Patient-centred questioning	Direct body orientation
Friendliness	Uncrossed legs and arms
Courtesy	Arm symmetry
Explanations	Less mutual gaze
Positive reinforcement	
Humour	
Psychosocial talk	
Time in health education and information sharing	
Orientating the patient to the examination	
Summarisation	
Clarification	

other UK study[17] examined the impact of matching/not matching the patient's vocabulary and found that patients who had their language matched had significantly higher satisfaction scores and higher ratings of rapport, communication comfort, distress relief and compliance intent.

However some studies have shown that there are also patient characteristics associated with patient satisfaction. A large Italian study[18] of type 2 diabetic patients undertook to identify the correlates of their satisfaction with their physicians. It was found that patient satisfaction with physicians' humanness and communication skills strongly related to personal characteristics, attitudes, expectations and perceived health. For example, patients with lower levels of school education were more dissatisfied about the information received and their involvement in the management of diabetes. Patients with worse health perception also showed lower levels of satisfaction. Therefore physicians may need to recognise patient attitudes and expectations and adjust their style to suit the patient.

One review[19] reported that there was not the evidence for a clear association between the doctor-patient interaction and patient compliance. However a meta-analysis[14] showed compliance was weakly associated with physician behaviour. In particular, compliance was associated with more information-giving and positive talk.

Table 3. The patient-centred clinical method[12]

1. Exploring both the disease and the illness experience
• differential diagnosis • dimensions of illness (ideas, feelings, expectations and effects on function)
2. Understanding the whole person
• the person • the context
3. Finding common ground regarding management
• problems and priorities • goals of treatment • roles of the doctor and patient in management
4. Incorporating prevention and heath promotion
• health enhancement • risk reduction • early detection of disease • ameliorating effects of disease
5. Enhancing the doctor-patient relationship
• characteristics of the therapeutic relationship • sharing power • caring and healing relationship • self-awareness • transference and countertransference
6. Being realistic
• time • resources • team building

Health outcomes and efficiency of care

Effective doctor–patient communication and health outcomes have been reviewed[20] and, of 21 studies, 16 reported positive results. The quality of both the history-taking and discussion of the management plan were found to influence patient health outcomes. The outcomes affected were emotional health, symptom resolution, function, physiologic measures and pain control.

The impact of patient-centred care on outcomes related to patient health and efficiency of care were assessed in a GP context.[21] It was reported that patient-centred communication was correlated with the patients' perception of finding common ground. Positive perceptions were associated with better recovery from discomfort and concern, better emotional health two months later and fewer diagnostic tests and referrals (reduction of 50%). This study did not show that the objective ratings of the patient-centredness of the consultation were related to outcome, but the patient's perception of patient-centredness. One explanation for this finding is that physicians may learn to 'go through the motions' but may not truly be attentive and responsive listeners.

2. Benefits for doctors in utilising the patient-centred approach and effective communication skills

Higher physician satisfaction

Physicians using a patient-centred style with good communication skills experience less frustration in their daily work and are more satisfied. In a study in primary care, interactions in which the physician was mainly responding to patient questions and giving information were associated with the highest physician satisfaction.[22]

Fewer malpractice claims

It is well accepted that it is not quality of care, medical negligence or chart documentation that are the critical factors in whether or not patients complain, but patient dissatisfaction. The combination of a bad outcome and patient dissatisfaction means that the patient is much more likely to complain. The largest factor in patient dissatisfaction is communication breakdown. One USA study[23] noted that, in a general practice setting, GPs that had no malpractice claims used more statements of orientation (informing patients about what to expect and the flow of the

visit), laughed and used humour more often, and used more facilitation skills (soliciting patient opinion, checking understating, and encouraging patients to talk). Their routine consultations were longer (18.3 vs 15 minutes) when compared to GPs who had received patient complaints.

3. What do patients say about the patient-centred approach?

In a large British study of patient preferences for patient-centred care,[24] patients clearly wanted the communication, partnership and health promotion aspects of patient-centred care. Those patients with very strong preferences for patient-centredness were those who were vulnerable either socio-economically or because they were particularly unwell or worried. However in some situations, e.g. in patients with breast cancer,[25] patients and doctors differ on what is important. This qualitative study found that patients were not primarily concerned with doctor's communication skills but they valued doctors whom they believed were technically expert, had formed personal relationships with them and respected their status as autonomous individuals.

Can doctors' communication behaviour be changed?

There are mixed findings in research designed to answer this question. On the one hand, some researchers have found that communication skills can be learned and physicians' interviewing skills enhanced.[2,26–29] Experiential methods of learning may be superior to didactic methods.[28] One USA study[30] of an intensive training programme for primary care trainees showed improvement in knowledge, attitudes and skills in interviewing. Agenda setting can also be learned.[30]

However a review of evaluation studies of communication skills training to experienced clinicians[31] found that positive training effects occurred in only half of observed behaviours. Since most studies involved self-selecting participants, these results may have arisen because the studies were assessing physicians who already had good skills. Alternative explanations for the limited effects of training in these studies are first, that physicians experience difficulties in translating the skills learnt into daily practice (and it may take time to do so) and secondly that physicians may have lacked the motivation to change their behaviour.

Another team of researchers[32] found that GP trainees' communication skills did not improve, even in a longitudinal programme that was rich in clinical context. These authors and others[33] suggested that communication skills programmes may need to be longer, more intensive, teach a broader range of skills, provide ongoing performance feedback, utilise patient feedback and use a variety of instruments to measure change in communication skills.

The largest factor in patient dissatisfaction is communication breakdown

Some new strategies in teaching communication skills hold promise. For example, an Australian GP training programme has reported on the use of patient feedback.[34] It was found that systematic patient feedback at regular intervals throughout GP training resulted in sustained levels of interpersonal skills. And another most innovative method of teaching communication skills has been reported in 2004[35] in which an analysis system was embedded within a software platform that presented fully coded interviews with instant search and review features. This system could overcome many logistical and time constraints in teaching from videoed consultations. In this study, paediatric trainees' performance significantly improved with increased empathy, use of open-ended questions, reduced verbal dominance, increased partnership building and problem solving for therapeutic regimen adherence – all accomplished with only four hours of teaching.

These authors[35] also showed that female physicians did better than their male colleagues after the communication course. The changes in the female physicians were in the areas that are known to be gender linked, i.e. psychosocial questioning, emotionally-focused talk and active partnership behaviours.[8]

So the question remains, how are communication skills best taught so they will be optimally utilised in the medical consultation? Since much can be learned by simply increasing one's awareness of what is happening during communication with the patient, some doctors will continue to favour the time-honoured methods emphasising key elements of good communication. One that is widely used in practical training has been reported in Colorado:[36] 'Invite, Listen and Summarise' that is, an open ended enquiry, attentive listening to build rapport, and then summarise by using reflective listening techniques.

Some will want to continue to search for better and more successful methods of teaching and learning. The following suggestions may be helpful:

Practical ways to increase your awareness and skill are:

- Choose to reflect on a consultation that went well/not so well and identify why;
- At the start of consults try two to three open questions, listen and then reflect back;
- Audiotape or videotape consultations and review them with a colleague;
- Invite patient feedback on your consultations;
- Work with others, e.g. peer group or through the RNZCGP to gain feedback on your consultation skills;
- Undertake short courses in communication/consultation skills.

- Check out this site:
  http://www.skillscascade.com

For the many doctors who find the whole process rather challenging, a new model,[37] which is also accessible on the web http://www.skillscascade.com, may help solve problems. It provides a diagram showing how the process of communication can be integrated into the traditional medical interview.

Conclusion

GPs need effective communication skills to be able to convey empathy, build and maintain therapeutic relationships with patients, and deliver high quality care. There are documented benefits to both patients and doctors and new evidence of this continues to emerge. GPs can improve their own communication and consultation skills through thoughtful reflection, self-monitoring and training methods.

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